

SCOOBY-DOO!

WELCOME



We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex M F Age _____

Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____

Street City State Zip

Mailing Address _____

Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____	Mother's/Guardian's Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home Phone (____) _____ <small>(if different from above)</small>	Home Phone (____) _____ <small>(if different from above)</small>
Work Phone (____) _____ <small>(if different from above)</small>	Work Phone (____) _____ <small>(if different from above)</small>
E-mail _____	E-mail _____
Employer _____	Employer _____
Soc. Sec. # _____ Birthdate _____	Soc. Sec. # _____ Birthdate _____
Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name _____ Phone (____) _____	Plan Name _____ Phone (____) _____
Address _____	Address _____
Group # _____ Policy # _____	Group # _____ Policy # _____
Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No	Child's Medical Assistance I.D. # _____

DENTAL HISTORY



Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form?.....	<input type="checkbox"/>	<input type="checkbox"/>
Does child brush teeth daily?.....	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth, head?	<input type="checkbox"/>	<input type="checkbox"/>
Does child use floss every day?	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now? YES NO Medications _____

Receiving any medication or drugs? YES NO _____

Ever been hospitalized? YES NO _____

Ever had surgery? YES NO Allergies _____

Is there excessive bleeding when cut? YES NO _____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____ Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____ Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed



Signature of Parent, Guardian or Personal Representative

Please print name of Parent, Guardian or Personal Representative

Date

Relationship to Patient

UPDATE

(To be completed at later visit)

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____



Mission Hill Dental

Dr. Horacio Lucero

Dr. Fred B. Willard

2732 Big Oak

New Braunfels, Texas 78132

Financial Policies

PAYMENT IS DUE AT THE TIME OF SERVICE. We accept cash, personal check, and all major credit cards. We require you to pay your estimated cost share at the time services are rendered. Any remaining balance will be billed to you once your insurance company has processed your claim. If any amount is left unpaid and collection fees are incurred, these additional fees will be added to the patient’s account balance and become the responsibility of the patient or guarantor on the account.

If you have insurance coverage, the insurance information must be supplied at the time of service. We will file up to 2 insurance claims, primary and secondary, as a courtesy for you. **You are responsible for any non-covered items or services. Not all services and supplies are covered by insurance. If you are not clear on the coverage and benefits of your plan, please call your insurance company to inquire what your out of pocket expenses will be for the services you receive.** Your policy is between you and your insurance company and coverage varies per policy, we cannot be involved in disputes over non-covered services or supplies. If your insurance has not paid our claim within 45 days from the date of service, we ask that you call your insurance company to expedite payment. After 60 days of non-payment, you will become responsible for the balance.

CANCELLATION POLICY: Please give 24 hour advanced notice if you are unable to keep an appointment so that we may open a slot for other patients in need. Failure to do this will result in a \$55 cancellation fee.

Please read and sign:

I will be responsible for any supplies or services which are provided to me.

I have been provided an opportunity to review the Notice of Privacy Practices regarding this office’s HIPPA compliance. I also have read the financial and cancellation policies listed above and agree to these terms.

Print Patient Name: _____

Patient Signature (Guarantor if a minor): _____ Date: _____

Mission Hill Dental Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other health care provider, a record of your visit is made. Typically, this record contains your symptoms, examination, and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with improving the health of the nation
- a source of data for facility planning and marketing
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

- ensure its accuracy
- understand who, what, when, where and why others may access your health information
- make more informed decisions when authorizing disclosure to others.

Your Health Information Rights:

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- request a restriction on certain uses and disclosures of your information
- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record
- amend your health record
- obtain an accounting of disclosures of your health information
- request communications of your health information by alternative means or at alternative locations
- revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities:

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us. We will not use or disclose your health information without your authorization, except as described in this notice.

Acknowledgement of Receipt
Of
Notice of Privacy Practices

I, _____ have received a copy of Mission Hill Dentals
(Name of Patient)

Notice of Privacy Practices.

(Signature of Patient)

Date: _____

For Office Staff Only

To be filled out if patient's signature not obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notices of Privacy Practices, but it could not be obtained for the following reason:

_____ Patient refused to sign.

_____ Emergency situations kept us from obtaining the patient's signature.

_____ Other

MISSION HILL DENTAL

Dr. Horacio Lucero

Dr. Fred B. Willard

2732 Big Oak, New Braunfels, TX 78132

830-625-7322 Phone

830-620-5709 Fax

www.missionhilldental.com

Dr. Lucero, Dr. Willard and/or their staff will not release dental information to or discuss dental information with anyone except the following people listed below unless permission is given in writing.

Name:	Relationship to patient:	Phone number:
<input type="text"/>		
Name:	Relationship to patient:	Phone number:
<input type="text"/>		
Name:	Relationship to patient:	Phone number:
<input type="text"/>		

Notice of Privacy Practice:

I hereby acknowledge that I have been presented with a copy of Dr. Lucero and Dr. Willard's Notice of Privacy Practice and that I have read and understand my rights.

Signature of Patient or Legal Guardian if patient is a minor

Date