Kids Smile Pediatric Dentistry
Mauricio Marcushamer, DDS
Tyrone Rodriguez, DDS

3006 Broadway Ste 103
San Antonio, TX 78209
210-225-8888

Child's Name_____ Date of Birth_____ Age_____ Sex: M F

Address_____ City_____ State_____ Zip_____

Home Phone_____ Mother Cell_____ Father Cell_____

Father's Name_____ DOB_____ Work Phone_____

Employer_____ SS#_____-_____-_____ Driver's License#_____

Mother's Name_____ DOB_____ Work Phone_____

Employer_____ SS#_____-_____-_____ Driver's License#_____

Parent Marital Status (circle one) Single Married Divorced Widowed Email_____

If you have any dental insurance, please provide the following information:
Name of Insurance Company_____ Name of Policy Holder_____

Whom may we thank for referring you: _____

You must have a current Medicaid card for a regular or emergency dental exam. It is also necessary for us to make a copy of your driver license and insurance card; please present it with this questionnaire and each time your child is seen by the dentist.
I hereby authorize payment directly to the above named dentist for dental treatment benefits if any, otherwise payable to me for services rendered. I understand that any balance remaining will be my responsibility.

X_____ Date _____
Signature of Responsible Party

CONSENT FOR TREATMENT
State law requires us to obtain your consent for contemplated treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.
1. I hereby authorize and direct Dr. Mauricio Marcushamer, assisted by other dentists and/or dental auxiliaries of his/her choice to perform upon my child (or legal ward) dental treatment or oral surgery procedure(s), including the use of any necessary or advisable local anesthesia, radiographs (x-ray) or diagnostic aids. All medical records and x-rays are property of this office.
2. In general terms the dental procedure(s) or operation may include:
   A. Cleaning of the teeth and the application of topical fluoride
   B. Application of plastic "sealants" to the grooves of teeth
   C. Treatment of diseased or injured teeth with dental restorations (fillings or crowns)
   D. Replacement of missing teeth with dental prosthesis
   E. Removal (extraction) of one or more teeth
   F. Treatment of diseased or injured oral tissues (hard and/or soft)
   G. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
   H. Use of physical restraint or restraining devices to safely accomplish the necessary dental procedures
   I. Use of sedative drugs to control apprehension and/or disruptive behavior (including Demerol, Versed, Hydroxyzine, and Nitrous Oxide/Oxygen)
   J. Use of General Anesthesia to accomplish the necessary treatment
3. I hereby authorize Dr. Mauricio Marcushamer and my child's physician to release any information necessary in the course of treatment of my child. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as the result of the treatment or as to cure. I further authorize the doctor to perform other dental service(s) that in his/her judgement are advisable for my child or legal ward, with the exception of (if none so state):_____
4. Although their occurrence is extremely rare, some risks have been reported to be associated with dental or oral surgery procedures. State law requires us to mention the possible risk of numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures. I further understand and accept that complications may require hospitalization and may even result in death. I hereby state that I have read and understand this consent, and that all questions have been answered in a satisfactory manner, and I understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment.
5. I further understand that this consent will remain in effect until such time that I choose to terminate it. I understand that parent(s) need to wait out in the waiting room while the patient is being treated and is not to leave the office.
6. Open areas are under surveillance.

X_____ Date_____ Office Reviewer_____
Signature of Parent or Guardian

☐ Yes ☐ No Is your child under the care of a physician?

☐ Yes ☐ No Has your child ever been hospitalized?
If yes, for what, when _____

☐ Yes ☐ No Has your child ever received general anesthesia?
If yes, were there any complications? _____

☐ Yes ☐ No Has any family member had complications during general anesthesia?
If yes, what? _____

☐ Yes ☐ No Is your child allergic to any medicine?
If yes, what? _____

☐ Yes ☐ No Is your child taking any medications at this time?
If yes, what? _____

Physician Name _____

Phone # _____

Address _____

_____

Date of Last Visit _____

Purpose of Last Visit _____

Has this child ever been diagnosed with any of the following conditions?

Yes	No		Yes	No		Yes	No	
☐	☐	Acid Reflux	☐	☐	Cystic Fibrosis	☐	☐	Mental Disability
☐	☐	ADD/ ADHD	☐	☐	Developmentally Delayed	☐	☐	Orthopedic Problems
☐	☐	Anemia/ Sickle Cell Anemia	☐	☐	Diabetes	☐	☐	Otitis (ear infection)
☐	☐	Asthma	☐	☐	Emotional Disorder	☐	☐	Pneumonia
☐	☐	Autism	☐	☐	Hearing Loss	☐	☐	Pregnancy
☐	☐	Autoimmune Disease	☐	☐	Heart Problems	☐	☐	Rheumatic Fever
☐	☐	Brain Injury	☐	☐	Hepatitis	☐	☐	Seasonal Allergies
☐	☐	Bleeding Problems	☐	☐	HIV (AIDS)	☐	☐	Spina Bifida
☐	☐	Cancer	☐	☐	Hyperactivity	☐	☐	Syndrome_____
☐	☐	Cerebral Palsy	☐	☐	Heart Condition	☐	☐	Other_____
☐	☐	Convulsions/Seizures/Epilepsy	☐	☐	Leukemia	☐	☐	Immunizations Up to Date

DENTAL HISTORY

Yes	No		Yes	No	
☐	☐	Does your child brush regularly?	☐	☐	Has your child been seen by a dentist before?
☐	☐	Is your drinking water fluoridated?	☐	☐	Has your child had any accidents involving his/her teeth?
		Does your child use:	☐	☐	Does your child have a dental condition that seems to "run in the family? (hereditary) If so, please indicate:
☐	☐	Fluoride vitamins?			_____
☐	☐	Fluoride rinse/gel?	☐	☐	Is there anything you would like to discuss personally with the dentist who examines your child?
☐	☐	Fluoride toothpaste?			

How do you expect your child to react to dental treatment?

☐ Very Well ☐ Moderately Well ☐ Not well Why: _____

f your child has any pets, hobbies, or special interests, please list: _____

X_____ Date_____ Office Reviewer_____

Signature of Parent or Guardian

HIPPA_____
Privacy Agreement_____

OFFICE USE ONLY
MEDICAL HISTORY ALERT

Kids Smile PC
3006 Broadway Suite 103 San Antonio, TX 78209

Except for life threatening emergencies, we **are not able to treat your minor child** unless he or she is accompanied to our office by a parent, legal guardian or designated adult. In order to designate an adult to bring your child into our office for dental care in your absence, you must have the following form completed, signed, and on file for each designated adult for each of your children. Minor children reporting for an appointment without a parent, legal guardian, an adult named in a signed designee form or a signed note from a parent may need to be rescheduled.

Alternate Caregiver Consent Form

I authorize the following individual(s) to bring my children to their dental appointments:

Name: _____ Relationship to my child:_____

Name: _____ Relationship to my child:_____

Name: _____ Relationship to my child:_____

I attest that the above named individual(s) are all 18 years of age or older as of this date. I authorize the above named individual(s) to consent to treatment for my children. This may include, but is not limited to, consent for necessary medications, procedures and hospitalizations. The practice may relay any medical information about my child necessary for the above named individual(s) to provide informed consent to the treatment.

I understand that the doctor will communicate his or her findings and treatment plan to the caregiver who brings in the child, and that under most circumstances, a follow up call to me personally should not be necessary.

I agree to hold Kids Smile PC and its staff harmless for any disagreement between the above named individual(s) and myself regarding treatment decisions.

I attest that I am the parent or legal guardian of the following children listed below and that I have the legal authority to make this agreement. I understand that I can revoke this authorization for any or all of these individuals at any time.

_____ Date: _____
Signature of Parent/Legal Guardian

_____ Phone: _____
Name of Parent/Legal Guardian (print)

Child's Full Name:_____ Date of Birth____/____/____

Child's Full Name:_____ Date of Birth____/____/____

Child's Full Name:_____ Date of Birth____/____/____

Child's Full Name:_____ Date of Birth____/____/____

Child's Full Name:_____ Date of Birth____/____/____

Child's Full Name:_____ Date of Birth____/____/____

Effective 1/1/2022

Attention All *PRIVATE* Insurance AND *Cash* Paying patients

There will be a ***$50 No Show / Missed appointment*** fee **PER** appointment(s) if not cancelled within 24 hours of scheduled apt time.

All Medicaid and Chip Patients

If your appointment(s) are not cancelled within 24 hours of scheduled appointment time we will be left with no choice but to notify your insurance regarding such missed/cancelled appointment(s).

IF our records indicate that there are Three (3) missed or cancelled consecutive appointment(s) within the same year a dismissal letter from our office will be sent out for the entire household on the third day of the missed or cancelled appointment(s)

_____ _____

Awknowledgment Signature Parent / Guardian Date

Thank you,
Kidssmile

KIDS SMILE,PC
3006 Broadway San Antonio, TX 78209

HIPAA & Notice of Privacy Practices

THIS NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

OUR LEGAL DUTY
As a recipient of health care services, you have certain rights. To learn more about these rights, we suggest you visit: https://www.hhs.gov/hipaa/for-individuals/index.html. We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We will follow the privacy practices that are described in this Notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will make commercially reasonable efforts to change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

OUR USE AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you only as necessary for treatment, payment, and our healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations including without limitation, quality assessment and improvement activities, reviewing the competence or qualifications of Health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us a written authorization, you may revoke it in writing at any time, although such revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we will not use or intentionally disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree in writing that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, concerning your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will (1) disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care and (2) use our professional judgment and experience with common practice to make reasonable inferences of your best interest in allowing third parties to pick up prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you may be a victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders.

PATIENT RIGHTS

Access: You have the right to review or obtain copies of your health information, with limited exceptions. You may request copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, health care operations and certain other activities, for the last 6years. We will provide such a list at no charge upon your request once in any 12 month period. We reserve the right to charge you for requests in excess of one per 12 month period.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Any such request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form upon your request.

QUESTIONS AND COMPLAINTS

To learn more about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Acknowledgement: I hereby acknowledge that I have read and fully understand the contents of this document, and I have been given the opportunity to ask any and all questions.

***By signing below, I acknowledge that I have read and understand this practices Notice of Privacy Practices**

Parent Signature: _____x **Date:** ____/____/_____