Grand Prairie Children's Dentistry

5115 Lake Ridge Pkwy., Ste. 200
Grand Prairie, TX 75052
972-522-0660

NEW PATIENT REGISTRATION

Welcome to our office! We like to begin by learning more about your child so we may provide the best possible personalized care.

1. Tell Us About Your Child

Child's Full Name _____ Prefers to be called _____ Today's Date __/__/____

Date of Birth __/__/____ Age ___ [ ] Male [ ] Female Names and ages of siblings _____

Home address _____ Parents' Marital Status: [ ] M [ ] S [ ] D [ ] Sep [ ] W

City _____ State ____ Zip _____ School _____ Grade _____

Home Phone _____ How did you hear about us? _____

2. Parent Information

[ ] Mother [ ] Father [ ] Step Mother [ ] Step Father [ ] Legal Guardian [ ] Other _____

Name _____ Prefers to be called _____ Date of Birth __/__/____

Address [ ] Same as child's _____ Occupation _____

City _____ State ____ Zip _____ Work Phone _____

Home Phone _____ Email _____

Cell Phone _____ Preferred method of contact _____

Is this person legally responsible for the health care decisions of the above patient? [ ] Yes [ ] No

3. Parent Information (If Applicable)

[ ] Mother [ ] Father [ ] Step Mother [ ] Step Father [ ] Legal Guardian [ ] Other _____

Name _____ Prefers to be called _____ Date of Birth __/__/____

Address [ ] Same as child's _____ Occupation _____

City _____ State ____ Zip _____ Work Phone _____

Home Phone _____ Email _____

Cell Phone _____ Preferred method of contact _____

Is this person legally responsible for the health care decisions of the above patient? [ ] Yes [ ] No

4. Person Responsible for This Account

Name _____ Relationship _____

Billing Address [ ] See Above _____ Home Phone _____

City _____ State ____ Zip _____ Work Phone _____

5. Dental Insurance Information (If Applicable)

Primary Insurance Co. Name _____ Insurance Co. Phone _____

Insurance Co. Address _____ Group# _____ Policy# _____

City _____ State ____ Zip _____ Social Security # _____

Policy Owner's Name _____ Policy Owner's Employer _____

Relationship to Patient _____ Policy Owner's Birthdate [ ] See Above ____/____/____

Thank you for your time. Please share with us any concerns you have or considerations you require.

Grand Prairie Children's Dentistry

5115 Lake Ridge Pkwy., Ste. 200
Grand Prairie, TX 75052
972-522-0660

New Patient Medical and Dental History

Child's Name _____ Today's Date ___/___/_____

Name and phone number of child's primary care physician: _____

Is your child under the care of any specialist physician? [ ] Yes [ ] No If so, please state name and specialty: _____

Date of your child's last medical check-up? ___/___/_____ Are all immunizations current? [ ] Yes [ ] No

Is your child allergic to anything? (e.g. Medications, Latex, Foods) [ ] Yes [ ] No

If so, what? _____

Is your child taking any medications at this time? [ ] Yes [ ] No If so, what? _____

Has your child ever been hospitalized? [ ] Yes [ ] No If so, for what? _____

Has your child ever had surgery or general anesthesia? [ ] Yes [ ] No **If so, were there any complications?** _____

Has your child ever been diagnosed as having any of the following conditions?

[ ] ADD/ADHD	[ ] Congenital Birth Defects	[ ] Nutritional Deficiency
[ ] Anemia	[ ] Diabetes	[ ] Orthopedic Problems
[ ] Arthritis	[ ] Emotional Disturbance	[ ] Premature Birth
[ ] Asthma	[ ] Eye Problems	[ ] Pregnancy
[ ] Autism	[ ] Fainting	[ ] Respiratory Syncytial Virus
[ ] Brain Injury	[ ] Handicaps/Disabilities	[ ] Seizure Disorder
[ ] Behavioral Problems	[ ] Hearing Impairment	[ ] Sickle Cell Anemia/Trait
[ ] Bleeding Problems	[ ] Heart condition/Heart murmur	[ ] Speech Problems
[ ] Breathing problems	[ ] Hemophilia	[ ] Spina Bifida
[ ] Cancer/Leukemia	[ ] Hepatitis	[ ] Syndrome(s) _____
[ ] Cerebral Palsy	[ ] Kidney/Liver Problems	[ ] Tetanus
[ ] Cleft Lip/Palate	[ ] Learning Disability	[ ] Other _____

Is this your child's first visit to the dentist? [ ] Yes [ ] No Dentist's name: _____ Date of last visit: ___/___/_____

Were there any complications associated with the previous dental care? [ ] Yes [ ] No If yes, please explain: _____

Were x-rays taken? [ ] Yes [ ] No If yes, do you have copies of the x-rays with you? [ ] Yes [ ] No

Has your child ever had any injuries to the teeth, face or mouth? [ ] Yes [ ] No If yes, please explain: _____

Does your child have any of the following habits? [ ] Thumb/Finger sucking [ ] Lip Sucking/Lip Biting [ ] Nail Biting [ ] Pacifier/Blanket

Does your child nurse or take a bottle? [ ] Yes [ ] No Does your child sleep with a bottle or sippy-cup? [ ] Yes [ ] No

How often are child's teeth brushed? _____ How often are child's teeth flossed? _____

Is your child's water fluoridated? [ ] Yes [ ] No Is the child receiving fluoride supplements? [ ] Yes [ ] No

What is your reason for bringing your child to the dentist today? _____

How do you think your child will react today? (e.g. cooperative, shy, anxious, defiant) _____

Is there anything else you think we should know about your child? _____

Name _____ **Signature** _____ **Date** ___/___/_____

Doctor's Signature _____ **Date** ___/___/_____

Thank you for your time. Please share with us any concerns you have or considerations you require.

Grand Prairie Children's Dentistry
5115 Lake Ridge Pkwy., Ste. 200
Grand Prairie, TX 75052
972-522-0660

OFFICE POLICY AND FINANCIAL AGREEMENT

We are so pleased you have trusted our office for the care of your child's smile. Helping families to understand oral healthcare is extremely important and we welcome parent presence during appointments for preventative care . For reasons of gaining and maintaining focus necessary for patient safety, parents are not present during appointments for the child's restorative treatments.

Scheduling and Cancellations
Because we value the time spent with our patients, appointments that you make are reserved solely for YOU and THE DOCTOR.
Please give our office consideration to fill your reservation if you need to cancel: allow our office at least 24 hours advance notice for cancellation. Any notice less than 24 hours will subject to $25 broken appointment fees.

Indemnity and PPO Insurance
We encourage you to familiarize yourself with your insurance benefits.
As a **courtesy** to our valued patients our office will directly bill the indemnity and PPO insurance for any treatment. However, we do ask our patients to be prepared to make payment toward their basic and major services, including fillings, crowns and extractions at the time these services are rendered.
Dr. Tak/Braidfoot is a Pediatric Specialist and our practice is committed to providing the best treatment for our patients. This office's charges are from our own fee schedule, based on what is usual and customary for specialists in our area. Your co-payments will be based on these fees.
Once your insurance company submits payment on the claim we will refund any over payment to you or bill you for any remaining balance on your account.
Our office will make every attempt to collect payment from your insurance company.
In the rare event that your insurance company does not pay within 60 days, the patient's parent or guardian will be responsible for the remaining balance in full.

Type of Payments Accepted
Cash, Checks, Visa, and MasterCard.

Returned Checks
There is a $50.00 fee for returned checks.
Once you have one returned checks from our office we will no longer accept personal checks.

Collections
Should there be any remaining balance on my account I agree to pay for services rendered upon notification by a representative of this office. I understand that if my account remains unpaid by me for a period of 30 days it may be referred to an attorney for collections. I agree to pay for all cost incurred including the initials balance plus the 35% attorney's fee (minimum of $50.00) and interest at 1/5% per month (18% annually).

I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES INCURRED AT THIS OFFICE

Patients Name _____ **DOB** _____

Parent/Guardian Signature _____ **Date** _____

Thank you for your time. Please share with us any concerns you have or considerations you require.

Grand Prairie Children's Dentistry
5115 Lake Ridge Pkwy., Ste. 200
Grand Prairie, TX 75052
972-522-0660

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*****You may refuse to sign this acknowledgement*****

I, _____, have received a copy

of this office's Notice of Privacy Practices.

_____
Please print child's name

_____
Parent's Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of

Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please explain) _____

_____

_____

_____

Thank you for your time. Please share with us any concerns you have or considerations you require.