Serengeti Smiles Pediatric Dentistry
7109 Navajo Trail
Lake Worth, TX 76135
817-238-6450

Welcome to Our Office! We appreciate your selection of this office to serve your child's dental health needs. Our goal in this practice is to provide the highest quality dental care for your child.
Your child's first visit consists of a thorough examination, x-rays when indicated and general instruction to the dental environment. Should your child have dental problems, they will be discussed with you and an estimate for the necessary services will be given. Corrective procedures will start on the second visit.

Please Print

PATIENT INFORMATION

Patient's **Full Legal** Name: ___________________________________Goes by: _____________________ Age: _________

Date of Birth: _________ /_________ /_________ Patient SS #_________ / _________ / _________ ☐ Male ☐ Female

Childs Home Address: ____
Street City State Zip Code

Child's Home # (_____) ____________________ With whom does child live? _____________________________________

Siblings we treat: ____

Name of school attending: ____ Grade: _______________________

Who can we thank for your referral? ____

NOTE: The Parent or Guardian who accompanies the child is responsible for Account and payments at time of service.

Who is Accompanying the child today?

Name: ____ Relation to child: ___________________________

Do you have Legal Custody of the child? ☐ Yes ☐ No

Please be aware if you are not the patient's legal guardian, you must have a letter from the Party giving you permission to bring the child to the appointment and make any dental decisions. If a letter is not provided we must reschedule their appointment until a letter is on file.

SOCIAL HISTORY

How do you expect your child to react today? ____

How does your child react to injury? ____________________________To stranger ___________________________________

Are parents divorced, separated or remarried? ____

Is your child adopted? ____

Does your child suffer from Emotional Issues/Stress? ____

What is your child's favorite pet, toy, sports or hobby? ____

Has your child had an unfavorable medical/dental experience? ___________ if yes, please explain: ___________________

____

Is there any advice you can give us regarding your child's personality or history that might be important in their care?

____

PARENT INFORMATION

Mother's Information: □ Mother □ Stepmother □ Legal Guardian

Full Name: ____ **Date of Birth:** _________ /_________ /________

SS #_________ / ________ / ________ **DL#** ____________________________________ **State** ______________________

Address: ____
Street City State Zip Code

Employer: ______________________________________ **Position:** ____

Home # _____________________ **Cell #** ______________________ **Work #** ________________________________

Email Address: ____

Father's Information: □ Father □ Stepfather □ Legal Guardian

Full Name: ____ **Date of Birth:** ________ /__________ /_________

SS #_________ / ________ / _________ **DL#** ____ **State** _____________

Address: ____
Street City State Zip Code

Employer: ______________________________________ **Position:** ____

Home # _____________________________ **Cell #** ______________________ **Work #** _________________________

Email Address: ____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE: In order for us to file your insurance all information must be provided.

Insured's Name: _______________________ **D.O.B** _______ / _______ / _______ **SS#** ________ / _______ / _________

Relationship to Patient: _______________**Employer:**_____________________**Occupation:** ___________________

Insurance ID# ______________________ **Insurance Company:** ____

Insurance# _________________________ **Insurance Address:** ____

____**Group #** ________________

****If your child has double coverage, please make sure we have Primary Insurance Information. We do not file secondary Insurance but we will provide you with claim information for your reimbursement. Primary Insurance is determined by the Birth Month. ****

EMERGENCY

In case of an emergency, whom should we contact?

Name: _______________________________ **Relationship:** ___________________ **Phone:** __________________

MEDICAL HISTORY

1. Is your child in good health? □Yes □No if no, please explain: ______________________________

2. Does your child have a persistent cough or throat clearing lasting more than 3 weeks? □ Yes □ No

If yes, please explain: ______________________________

3. Child's physician: ______________________ Telephone number: ______________________

4. Is your child under the care of a physician now? □ Yes □ No if yes, please explain:

____

5. Is your child current on all vaccinations? □ Yes □ No

6. Has your child ever been hospitalized? □ Yes □ No if yes, please explain:

____

7. Has your child had a blood transfusion? □ Yes □ No if yes, please list date: ______________________

8. Is your child taking any medications? □Yes □ No if yes, please list and explain: ______________________

____

9. Is your child **ALLERGIC** to any drugs or medications? □ Yes □ No if yes, please list: ______________________

____

10. Is child **ALLERGIC** to: □ Latex □ Dental Anesthetics (Novocaine) □ Nickel □ Food Allergies

If yes, please list: ______________________ other: ______________________

11. Does your child have a history of Acid Reflux? □ Yes □ No if yes, please explain: ______________________

____

12. Does your child have a history of upset stomach? □ Yes □ No if yes, please explain: ______________________

____

13. Is your child taking any herbal supplements? □ Yes □ No if yes, please list:

____

14. Was Pregnancy Normal? □ Yes □ No if no, please explain: ______________________

15. Was baby full term? □ Yes □ No if no, how many weeks: ______________________

16. If your child is female, what is the approximate date of her first menses? ______________________

★Has your child ever had or currently has one of the following:

Please check Yes or NO	Yes	No		Please check Yes or NO	Yes	No
Allergies				Epilepsy		
Asthma				Fainting		
Anemia				Hearing loss/ Speech Disorder		
AIDS				Hepatitis		
Blood Disorder				Kidney Disorders		
Bleeding Disorder				Liver Disease		
Cancer				Lung Disease		
Cerebral Palsy				Mental/ Behavioral disorder		
Congenital Heart Defect /Murmur				Rheumatic Fever		
Convulsions				HIV Positive		
Diabetes				Tuberculosis		

★★If you answered yes to any above, please explain: ______________________________

____

Dental History

1. Why did you bring your child in today? ____

2. Is this your child's first visit to the dentist? ☐ **Yes** ☐ **No**

3. If no, who was your child's previous dentist? ____

4. Who is your family dentist? ____

5. How often does your child brush? _________________________________ **Floss**____

6. Are parents in good health? ☐ **Yes** ☐ **No**

7. What is your water source? ☐ **Public health** ☐ **Private well**

8. Is the child's water fluoridated? ☐ **Yes** ☐ **No**

9. Is your child taking fluoride supplements? ☐ **Yes** ☐ **No**

10. Has your child had any injuries to the mouth or teeth? ☐ **Yes** ☐ **No If yes, please explain:** _____________________________________

12. Has your child had an orthodontic evaluation or previous treatment? ☐ **Yes** ☐ **No by whom** _________________________________

13. Does your child snore at night or sleep with their mouth open? ☐ **Yes** ☐ **No**

14. Does your child have persistent bad breath? ☐ **Yes** ☐ **No**

15. Is there a family history of?

(A) Severe dental crowding ☐ **Yes** ☐ **No**

(B) Missing teeth ☐ **Yes** ☐ **No**

(C) Tumors ☐ **Yes** ☐ **No**

(D) Extra teeth ☐ **Yes** ☐ **No**

(E) Bad bite ☐ **Yes** ☐ **No**

(F) Mismatched jaw ☐ **Yes** ☐ **No If yes, please explain:** ____

16. does your child currently:

(A) Suck/bite lips? ☐ **Yes** ☐ **No**

(B) Suck thumb, finger, and pacifier? ☐ **Yes** ☐ **No**

(C) Grind or clench teeth? ☐ **Yes** ☐ **No**

(D) Take a bottle at night? ☐ **Yes** ☐ **No**

AUTHORIZATIONS AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health and it is my responsibility to inform the dental office of any changes in my child's medical status.

Signature of Parent/Guardian _________________________________ **Relationship** ______________________ **Date** _________________

***I have read and have had any questions I may have had concerning any of the above statement answered to my complete understanding.** _________ **(please initial)**

CONSENT FOR TREATMENT OF A MINOR

The undersigned hereby authorize Dr. Martin/Dr. LaHue/Dr. Shin-Kim to perform the examination including x-rays, and after explanation. All forms of treatment, medication and therapy indicated for the dental care of the above-named child. This consent shall remain in force and effect until cancelled by either party in writing.
I authorize Dr. Martin/Dr. LaHue/Dr. Shin-Kim and staff to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health care providers.

Signature of Parent/Guardian ___________________________ **Relationship** _______________________**Date** _____________

Serengeti Smiles Pediatric Dentistry
POLICY PAGE

We want to welcome you to our office. Below is a summary of our office policies which we hope will provide you with the information necessary to make informed decisions about your child's dental needs.

Appointment:

Call the office at 817) 238-6450 twenty-four hours prior to an appointment if the appointment is not going to be utilized, cancelled or needs to be postponed.

We reserve the right to charge $50 for "NO SHOW" appointments or those without 24 hours' cancellation notice.

Please be aware patients that arrive more than 5 minutes late for their appointments may be asked to reschedule.

If your child needs antibiotics before their dental appointment, as a parent or guardian, it is your responsibility to call our office to inform us to call the antibiotics in to the pharmacy that you wish 2 days prior to your child's appointment.

Payments:

We collect all co-pays, deductibles and co-insurance at the time of service according to the benefit quote that our office obtains from your insurance company.

We have a $35.00 fee for all returned checks.

After Hour Calls:

There is a $100.00 charge for all after hour urgent visits.

Holidays:

The office is closed for all major holidays. For emergency calls, parents are to call our office and our answering service will transfer you to the office that is on call.

Inclement weather:

For inclement weather office hours, our office follows the Lake Worth ISD school closure schedules. For emergency calls when the office is closed due to inclement weather, please call our office and our answering service will contact Dr. Martin.

Dr. E Dale Martin, Dr. LaHue, and Dr. Shin-Kim see patients 0-14 years of age.
Once the child turns 15 years of age, we recommend that they see a general dentist.

Initials: ________________

Serengeti Smiles Pediatric Dentistry
CONSENT TO TREAT AND FINANCIAL AUTHORIZATION

CONSENT TO TREAT:

The undersigned consents to any examination or dental treatment, and or services rendered to the patient by Dr. Martin, Dr. LaHue, and Dr. Shin-Kim in their best judgment during the course of diagnosis and treatment. It is understood that the practice of dentistry is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment.

FINANCIAL RESPONSIBILITY:

It is accepted that regardless of any and all assigned benefits and or monies the undersigned agrees to be responsible for the total charges for services rendered. I agree that any amounts that may be my responsibility are due upon request, payable to Serengeti Smiles Pediatric Dentistry. Should this account become delinquent, I agree to pay all expenses including attorney fees. If this account has a credit balance at any time, I agree that it will be applied to any previous outstanding balance prior to any monies being refunded.

ASSIGNMENT OF BENEFITS AND INSURANCE REQUIREMENTS:

In consideration of goods and services rendered or to be rendered, I irrevocably assign and transfer to Serengeti Smiles Pediatric Dentistry all rights, title and interest in benefits or monies payable for goods and services. I understand that in the event that Serengeti Smiles Pediatric Dentistry files a claim on my behalf that the same does not impose any contractual obligation upon Serengeti Smiles Pediatric Dentistry, and that remain responsible for instituting suit within the applicable statue of limitations. I authorize
Pre-certification, pre-authorization, or second opinions shall remain the sole responsibility of the patient (and or parent or guardian), or legal agent. I authorize payors listed herein and any other payors to release any and all information requested and or related to my claims to
Serengeti Smiles Pediatric Dentistry.

THE UNDERSIGNED CERTIFIES THAT HE OR SHE HAS READ AND ACCEPTS THE CONSENT TO TREAT AND AUTHORIZATION, AND IS THE LEGAL PARENT OR GUARDIAN OF THE PATIENTS, OR THE LEGAL REPRESENTATIVE OF THE PATIENTS.

______________________	______________________	______________________
Signature	Relationship	Date

Serengeti Smiles Pediatric Dentistry
FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

• Payment for services is due at the time services are rendered. We accept cash, checks and credit cards. (VISA, MasterCard and Discover). There will be a $35.00 service charge for all returned checks.

• You may assign insurance payment to our office and we will file your primary insurance for you. Our office does not file secondary insurance. We can provide you with a statement form for you to submit to your secondary insurance for reimbursement.

•We verify insurance benefits prior to your child's appointment. We ask that you present your current insurance card at every visit so that the office staff may copy it. Failure to update our office with the correct insurance information prior to the appointment will result in you being responsible for payment of all fees or you may reschedule the appointment.

• Our office staff is only given a quote of benefits by your insurance company. It is never a guarantee of payment. We do our best to verify co-pays and deductibles; however, ANY portion that is applied to patient responsibility by the insurance company is due in full at the time of service. If you have any questions about your benefits we recommend you contact your insurance company so that they can explain your benefit package to you. Similarly, you can ask our staff about the benefits that were quoted.

• The parents/guardian must update new address and phone information with the front office staff. Failure to do so will result in statements being undeliverable and accounts possibly being sent to collections. Accounts that remain unpaid will be sent to a collection agency for further collection proceedings and will result in the family being dismissed from the practice.
If you have questions about your account please call our office at
817-238-6450 and speak to someone in the billing department. We are happy to assist you in any way that we can.

• Refunds must be requested from the office for any credit balance you may have on your account. They will not be automatically issued. Please allow ten business days to process.

• The parent or guardian who brings the child for treatment is the responsible party. This parent is required to pay for services rendered regardless of what a divorce decree may state.

______________________________ ______________________________ ________________

Signature of Parent/Guardian **Relationship** **Date**

Serengeti Smiles Pediatric Dentistry
CONSENT FOR TREATMENT AUTHORIZATION

Child's Name: ______________________________________ **Date of Birth:** ____________________

Parent or Legal Guardian's Printed Name: ____

I hereby authorize the following person(s) to seek dental services and treatment for my child as recommended or provided by Dr. E Dale Martin, Dr. Camille LaHue, and Dr. Sarah Shin-Kim.

____ ____

Printed Name **Relationship** **Phone Number**

____ ____

Printed Name **Relationship** **Phone Number**

____ ____

Printed Name **Relationship** **Phone Number**

____ ____

Printed Name **Relationship** **Phone Number**

You must choose one of the following in order for form to be valid.

For the following period:

□ ___________________________ **through** ____

□ **Until such time as this authorization is revoked in writing.**

__________________________________ _________________________ ____________________

Signature of Parent/Guardian **Relationship** **Date**

Serengeti Smiles Pediatric Dentistry

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

____

Please PRINT name

____

Signature

____

Date

FOR OFFICE USE ONLY

The patient was offered a copy of the Notice of Privacy Practices. An attempt was made to obtain a signature on this Acknowledgment of Receipt for the notice. Signature was not obtained because:

- □ **Individual refused to sign**
- □ **Parent stated that a copy was received previously prior to treatment of sibling.**
- □ **Communication or language barrier.**
- □ **Emergency situation prevented obtaining acknowledgment.**
- □ **Other (specify below)**

____

____

Received by: ____ Date: _______________
Staff member