Red Balloon Dentistry for Children

Patient Information

Name: _____ Date of Birth: _____ Sex: ____ M ____ F
Address: _____ City: _____ Zip Code: _____
Phone #: _____ Additional #: _____ Email: _____
Are any siblings patients of record? If yes, please list their names: _____
Whom may we thank for referring you to our office? _____

Parent/Guardian Information

_____ Mother _____ Father _____ Guardian
Name: _____ Date of Birth: _____ SSN: _____
Address: _____ City: _____ Zip Code: _____
Employer: _____ Work#: _____
Home #: _____ Cell #: _____ Other #: _____

_____ Mother _____ Father _____ Guardian
Name: _____ Date of Birth: _____ SSN: _____
Address: _____ City: _____ Zip Code: _____
Employer: _____ Work#: _____
Home #: _____ Cell #: _____ Other #: _____

Insurance Information

As a courtesy, we will accept assignment of benefit from most insurance companies. In order to do so, you must provide us with the following information.
Dental Insurance? _____ Yes _____ No If yes, please fill out the following information:
Name of person insured: _____ Relationship to patient: _____
Insured SSN/ ID#: _____ DOB: _____ Employer: _____
Insurance Company: _____ Phone #: _____ Group #: _____

Dental History

Why is your child here today? _____ Is this their first dental visit? _____
If no, date of last dental visit: _____ And reason for the visit: _____
Will your child be a cooperative patient? _____ Yes _____ No
Please describe how you think your child will behave today. Check all that apply:
_____ Friendly _____ Happy _____ Anxious _____ Timid _____ Afraid _____ Resistant
Does or did your child receive fluoride in any forms? _____
Has your child had any of the following: _____ Cavities _____ Crooked teeth _____ Sensitive to hot/cold _____ Loose teeth
_____ Toothache _____ Sensitivity to sweets _____ Frequent headaches _____ Bad breath
_____ Bleeding gums _____ Discolored teeth
Does your child have any of the following oral habits? _____ Thumb sucking _____ Pacifier use _____ Lip biting
_____ Teeth Grinding _____ Finger sucking _____ Excessive lip licking
How often does your child brush? _____ How often does your child floss? _____
At what age did your child stop using the bottle? _____ Sippy Cup? _____

Medical History

Child's Physician: _____ Phone #: _____
If your child in good health? _____ Yes _____ No
If no, please describe: _____
Are your child's immunizations and booster shots up to date? _____ Yes _____ No
Has your child ever been hospitalized or had surgery? _____
Is your child taking any kind of medication (prescription or over the counter)? Please list: _____
_____

Has your child ever had a reaction to or problem with anesthesia? If yes, please describe: _____
_____

Does your child have any drug allergies? If yes, please list: _____

Is your child allergic to anything? If yes, please list: _____

Please circle yes or no for any of the following conditions your child has had or now has:

Complications before during birth/ prematurity	Y/N	Impaired vision, hearing, or speech	Y/N
Syndromes/ Genetic Disorders	Y/N	Convulsions/seizures/ Cerebral Palsy	Y/N
Sinus Problems/ chronic adenoid/tonsil infections	Y/N	Hydrocephaly or placement of shunt	Y/N
Seasonal Allergies	Y/N	ADD/ADHD	Y/N
Asthma	Y/N	Autism Spectrum Disorder/ developmental delays	Y/N
Sleep apnea/snoring/mouth breathing	Y/N	Diabetes	Y/N
Heart trouble	Y/N	Thyroid problems	Y/N
Congenital heart defect/ Heart Murmur	Y/N	Anemia/ blood disorders/ sickle cell disease	Y/N
Rheumatic fever	Y/N	Excessive bleeding	Y/N
High/Low Blood Pressure	Y/N	Blood transfusion	Y/N
Cystic Fibrosis	Y/N	Cancer, tumors, or chemotherapy	Y/N
Frequent colds or coughs, or pneumonia	Y/N	Tuberculosis exposure	Y/N
Jaundice/ Hepatitis/ Liver problems	Y/N	HIV/AIDS	Y/N
Acid reflux disease/Stomach ulcers/ intestinal problems	Y/N	Cleft lip or palate	Y/N
Frequent diarrhea, weight loss, eating disorder	Y/N	Other: _____	
Bladder or kidney problems	Y/N	_____	

Authorization and Release

I understand that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependent (s), including any balance not paid by my dental insurance company within 30 days of statement date. I understand that any unpaid balances may be sent to a collection company and I will be responsible for all collection charges. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or rental group any insurance benefits otherwise payable to me. 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. It is my responsibility to inform this dental office of any changes in my child's medical status. I authorize this office to release any information, including the diagnosis and records of treatment or examination rendered to any child during the period of such dental care to third party payers and or other health practitioners.

Signature of Parent or Guardian: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____ **Witness:** _____

Red Balloon Dentistry for Children

Austin
1139 W. Braker Ln, Suite 201
Austin, TX 78758
P: 512-502-5432

Leander
1907 S. Hwy 183, Suite 206
Leander, TX 78641
P: 512-817-4940

Financial Policy

To reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

• Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we will accept cash, check, visa, master card, discover and American Express. The **adult accompanying** the child is responsible for payment for services rendered to a child patient.

• Your insurance is a contract between you and your insurance company. As a courtesy, after your first initial visit and upon verification of coverage, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

• We are contracted with MOST dental insurance plans. If you are covered by one of these plans, we will bill your plan and will only require you to pay your estimated copayment at the time of service. Any remaining balance would be due upon receipt of our statement. We also accept Traditional Medicaid and Texas Chips, as well as Delta Dental, MCNA and DentaQuest Medicaid and Chips plans, including the Star program.

• All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be “not covered” or over what they deem “usual and customary charges”’ you will be responsible for this amount. Payment is due upon receipt of statement from our office. If payment is not made upon receipt of our statement, we will no longer file your insurance. Therefore, we will expect payment in full at the time of service. We do honor some Discount Dental plans so please ask our front office staff to see if we accept your plan.

• Your estimated portion of our fees for scheduled hospital procedures is due when scheduling the surgery date. Any balance remaining after your dental plan pays is your responsibility and payment is due upon receipt of statement from our office.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms.

Patient’s Name: _____

Signature of Parent or Guardian: _____ **Date:** _____

Consent for Anxiety Reducing Techniques

Please read this form carefully and ask questions about anything you do not understand. Please check each box to identify that you understand this technique.

All efforts will be made to obtain the cooperation of child dental patients using Tell-Show-Do with friendliness, persuasion, humor, charm, gentleness, kindness and understanding. In some cases, further techniques are needed when providing operative care such as fillings, etc. To gain cooperation, eliminate disruptive behavior or prevent a patient causing injury to themselves, it may be necessary to use other anxiety reducing techniques.

☐ **Tell-Show-Do:** The dentist or dental team explains to the child what is to be done using simple, kid-friendly terminology and repetition, then shows the child what is to be done by demonstrating with instruments on a model or the child's or the dentist's finger. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

☐ **Positive reinforcement:** This technique rewards the child who displays behavior which is desirable with compliments, praise, pat on the back, or a prize.

☐ **Mouth Props/Rubber Dams:** A mouth prop, or tooth pillow as we call it, is used to help support your child in keeping his/her mouth open during an operative procedure (fillings, etc). This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a raincoat placed on the area to be worked on to isolate the teeth and prevents any debris from being swallowed or from going to the back of the throat.

☐ **Immobilization by dentist:** In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the dentist gently holds the child's hands or upper body, stabilizing the child's head between the dentist's arm and body.

☐ **Immobilization by the assistant:** In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the assistant gently holds the child's hands and stabilizes the child's head and/or legs.

☐ **Relaxation Gas:** Nitrous Oxide (laughing gas) and oxygen may be recommended to relax the child. This allows the child to sit in the chair longer, increases their attention span and allows the treatment to be completed in a comfortable manner for the child.

☐ **Voice Alteration:** A controlled alteration (increase or decrease) of voice, tone, or pace to influence and direct the patient's behavior.

I acknowledge that I have read these statements and agree to the contests.

Signature of Parent or Guardian: _____ **Date:** _____

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Acknowledgement of Receipt of Notice of Privacy Practice

Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Patient's Name: _____

Please print your name here: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency, it was not possible to obtain an acknowledgement.

☐ We were not able to communicate with the patient.

☐ Other (Please provide specific details)

_____
_____
_____
_____

Employee Signature: _____

Date: _____

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Authorization – Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person brining your child will need to present a photo identification at time of service.
This authorization gives the person permission to bring your child(ren) in, speak to the doctor, given authorization for treatment, medication, certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to Red Balloon Dentistry for Children and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider. I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

Name of Person (allowed to bring child) _____Relationship _____

Name of Person (allowed to bring child) _____Relationship _____

Name of Person (allowed to bring child) _____Relationship _____

Please print your name here: _____

Signature: _____

Date: _____

Red Balloon Dentistry for Children

Appointment Consent

I attest that the information I have provided on this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office on any changes in my child's medical status.

I understand that signing below I authorize the following procedures to be performed as deemed necessary by the dentist and have read and understand the possible risks and complications of each procedure.

X-rays and Examination
I understand that my child will be receiving a dental examination from a state licensed dentist. I understand that x-rays may be taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Medical Photography Consent
I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purpose of identification and dental treatment.

Dental Cleaning and Fluoride Treatment
I authorize Red Balloon Dentistry for Children and their staff members to clean my child's teeth today. I understand that the application of fluoride is part of the standard of care for children and helps to prevent cavities.

Drugs and Medication
I understand that antibiotics, analgesics, and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

I understand that all the above treatments are the standard of care in dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments.

Optional Photography Consent
I consent to having my child's photo taken and displayed in the office as part of contests or bulletin boards.

☐ I consent ☐ I do not consent

I consent to having my child's photo taken and posted as part of online social media including, but not limited to: the office website, Facebook and Google.

☐ I consent ☐ I do not consent

Patient's Name: _____ **Time:** _____

Signature of Parent or Guardian: _____ **Date:** _____

Printed Name: _____ **Relationship:** _____ **Witness:** _____