STONEBRIAR FAMILY DENTISTRY

Sanjukta Chitre, DDS ● 3685 Preston Road, Suite 145, Frisco, TX 75034● 972-377-5516 ● www.yourfriscodentist.com

WELCOME

Welcome to Stonebriar Family Dentistry. Our main goal is to help provide you with personalized, comprehensive care that is tailored to your child's unique dental needs and goals. We believe open communication builds the trust needed for long-lasting, trusting patient-doctor relationships. **Please fill out this form as completely as possible for your child**. This will help us in making your transition to our office as smooth as possible.

ABOUT YOUR CHILD:

Today's Date: _____ How did you hear about us? _____

Name (First, MI, last): _____

What would your child prefer to be called: _____

Circle one: **Male** **Female** Birthdate: _____Age:_____

Address: _____

City: _____ State: _____ Zip: _____

PARENT INFORMATION:

Mother's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

When and where are the best times to reach you? _____

Father's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

When and where are the best times to reach you? _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Contact Number: _____

DENTAL INSURANCE:

Person responsible for Account _____

Does your child have dental insurance coverage: **Yes** **No**

Dental Insurance Co. Name: _____

Dental Insurance Co. Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance Co. Phone: _____

ID #: _____ Group # _____

Insured Name: (if not patient): _____

Relationship to patient: _____ Insured's Birthdate: _____

Insured's SS#: _____ Insured's Phone: _____

Insured's Employer: _____Occupation: _____

ACKOWLEDGEMENTS & SIGNATURES:

I acknowledge that the information I give in this form is to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my child's insurance or medical status.

I understand that I will be required to pay my estimated portion of Dr. Chitre's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature of Parent/Guardian: _____

Date: _____

DENTAL HISTORY:

Why has your child come to our office today? _____

Is your child in pain? **Yes** **No** If yes, for how long? _____

Previous Dentist: _____

Phone: _____ Last Visit Date: _____

Date of last Cleaning: _____ Date of last Dental X-rays: _____

Has your child had any problems with dental treatment in the past? **Yes** **No**

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

Has your child ever had any kind of orthodontic treatment? **Yes** **No**

Is your child anxious about their visit today? **Yes** **No**

On an average how many times a day does your child brush? _____

Does your child floss? **Yes** **No**

Does your child take fluoride supplements? **Yes** **No**

How would you describe your child's eating habits? _____

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MEDICAL HISTORY

Patient Name: _____ Birth Date: _____

It is very important that we have an accurate record of your health status and any medication that you are currently taking. This at times can have a direct connection with dental findings and the treatment that you will receive. Thank you for answering the following questions.

	Yes	No	Please explain
Is your child under a physician's care now?			
Have your child been hospitalized in the last 2 years?			
Have your child ever had a serious head or neck injury?			
Is your child taking any medication (OTC or Prescription)?			

ALLERGIES:

	Yes	No	Please explain
Aspirin			
Penicillin			
Latex			
Sulpha drugs			
Codeine			
Local Anesthetics			
Metal			
Other			

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No
Anemia			Leukemia		
Asthma			Mumps		
Arthritis			Measles		
Bleeding disorder			Rheumatic fever		
Cancer			Seizures		
Chicken pox			Sickle Cell Anemia		
Diabetes			Hypo/Hyper Thyroidism		
Epilepsy			Tuberculosis		
Growth Disorders			Sensory Disorders		
Hearing Disorders			Eating Disorders		
Heart Murmur					
Hepatitis					
Jaundice					

Has your child ever had any serious Illness not listed above? **Yes / No**

If Yes, Please explain: _____

I have answered all the above questions accurately. I understand that DR. Chitre is basing her treatment taking into account the above information. It is my responsibility to inform the dental office of any changes in my child's medical status.

Signature of Patient, Parent or Guardian: _____ Date: _____

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Patient Name: _____ Birth Date: _____

GENERAL CONSENT:

I understand that the initial visit for my child will require radiographs in order to complete the examination, diagnosis and treatment plan and a preventive (regular) cleaning will be completed. By signing below, I am giving my consent for my child to have radiographs taken and have a preventive(regular) cleaning done.

Signature of Patient, Parent or Guardian: _____ Date: _____

_____

FINANCIAL AGREEMENT:

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

For your convenience we offer a wide range of financial options in order to pay for your dental treatment:

A) **Prepayment in Full**: For any treatment over $500, a prepayment courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

B) **Pay as You Go**: You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

C) **In-House Financing**: We offer No Interest Financing for up to 6 months with affordable monthly payments. There is a 5% management fee, NO CREDIT CHECKS and no prepayment penalties.

D) **Care Credit:** Care Credit offers No Interest financing for up to 24 months and low monthly payment options. There are no upfront costs, no prepayment penalties and no fees as long as it is paid in full by the end of the term. This allows you to get the necessary work done now and pay later.

In order to facilitate access to the very best dental care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks or Care Credit (see above).

By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees for services rendered. We will gladly assist you in any way we can. I understand that if I become delinquent on my account, my account will be turned over to a collection agency. Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered. After your dental insurance has paid for dental services rendered at Stonebriar Family Dentistry you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe.

I certify that I have read, fully understand, and accept the above financial policy.

Signature of Parent or Guardian: _____ Date: _____

_____

APPOINTMENT POLICY:

At the Stonebriar Family Dentistry, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily. Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment. If you find that you cannot keep your appointment, we do require a minimum notice of 48 business hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 business hours, you will be subject to a **$50 per hour scheduled**, late cancellation charges.

By signing below, I agree to fulfill my obligation as a patient at the Stonebriar Family dentistry and agree to the "broken appointment" fee should I not give proper notification.

Signature of Parent or Guardian: _____ Date: _____

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Patient Name: _____ Birth Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received, read and understand your Notice of Privacy Practices. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the above given address to obtain a current copy of the Notice of Privacy Practices. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor / facilities in the future.

Patient Name: _____ Parent/Guardian Name: _____

Signature of Parent/guardian: _____ Date: _____

OFFICE USE ONLY

I attempted to obtain patient's signature in acknowledgement on the Notice of privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____

CONSENT/ LIMITED AUTHORIZATION FOR ACCESS TO RECORDS:

Please list any other parties who can have access to your health information: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I authorize the above mentioned people to have access to my medical and dental records including but not limited to my health history, radiographs, insurance and billing information and diagnosis and recommended treatment.

Signature of Parent/Guardian: _____ Date: _____
