We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health

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Name of Minor/Child:_____
Last First Middle Initial

Birthdate: _____ Age: _____ Sex: ☐ Male ☐ Female

Nickname:_____ Hobbies: _____

Patient's Primary Language Spoken: ☐ Spanish ☐ English ☐ Other: _____

Patient's Address: _____
(Street /P.O. Box)

_____
(City) (State) (Zip)

Patient's Ethnicity: ☐ White ☐ Black/African American ☐ Hispanic/Latino ☐ American Indian/Alaska Native

☐ Asian ☐ Native Hawaiian/Other Pacific Islander

☐ More than one race: _____

Parent/Gaurdian Name: _____

E-mail Address: _____

Cell: _____ Home:_____Work:_____

Whom may we thank for referring you? _____

INSURANCE

Do you have dental insurance coverage for minor/child? ☐ ***Yes*** ☐ ***No***

Person Financially Responsible: _____
(Last) (First) (Middle Initial)

Date of Birth:_____ SS#:_____

Home Number: _____ Cell:_____ Work: _____

Address (*if different from patient's*): _____
(street/P.O. Box)

_____
(City) (State) (Zip)

Plan Name: _____ ***Phone#:*** _____

Employer: _____ ***Group#:*** _____ ***Policy or Member#***_____

_____***Initials*** ***CANCELLATION POLICY***: *As a courtesy to other patients, all cancellations must be made* ***24 hours*** *in advance of any scheduled appointments. If cancellations occur after this time, your account may be charged a cancellation fee. If you do not show for your scheduled appointment, your account may be charge a* ***"No-Show"*** *fee of $50.00 or more.* ***972.772.4000***

PATIENT NAME:_____

DENTAL HISTORY

Date of last visit to a dentist: _____ For what Service?:_____

Has child complained about dental Problems?..... ☐ Yes ☐ No

Does child brush teeth daily? …… ☐ Yes ☐ No

Does child use floss every day? …… ☐ Yes ☐ No

Is fluoride taken in any form? …… ☐ Yes ☐ No

Any injuries to mouth, teeth, head?..... ☐ Yes ☐ No

Any unhappy dental experiences? …… ☐ Yes ☐ No

Any mouth habits- thumbsucking, nail biting, pacifier, sleep with bottle, ect? ☐ Yes ☐ No

MEDICAL HISTORY

Minor/Child's Physician: _____City/State: _____ Phone#: _____

Is minor/child under care of physician now?..... ☐ Yes ☐ No **Medications**:_____

Receiving any medication or drugs?..... ☐ Yes ☐ No _____

Ever been hospitalized?..... ☐ Yes ☐ No _____

Ever had surgery?..... ☐ Yes ☐ No **Allergies**:_____

Is there excessive bleeding when cut?..... ☐ Yes ☐ No _____

Has minor/child had any history of or difficulty with any of the following? If yes please circle.

A.I.D.S./H.I.V	Cerebral Palsy	Epilepsy	Kidney Disease	Rheumatic Fever
Anemia	Chicken Pox	Fainting	Liver Disease	Sinus Problems
Asthma	Convulsions	Hearing Problems	Measles	Thyroid Disease
Bladder Problems	Diabetes	Heart Problems	Mononucleosis	Tuberculosis
Cancer	Drug/Alcohol Abuse	Hepatitis	Mumps	Other

Has a physician or previous dentist recommended that minor/child take antibiotics prior to their dental treatment? ☐ Yes ☐ No
Have you ever had any serious illness not listed above: ☐ Yes ☐ No If yes, please explain:

_____

To the best of my knowledge, the question o this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the Patient's) health. It is my responsibility to inform the dental office of any changes in medical status .

SIGNATURE OF PARENT, OR GUARDIAN DATE

PATIENT NAME: _____

Rockwall Family Dentistry

3084 N Goliad St, Suite 124
Rockwall, TX 75087
972.772.4000

I understand and agree that all services rendered me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid in accordance with the provisions herein, reasonable attorney's fees, plus applicable finance charges and disbursements, allowances and costs provided by law shall be included in the computation of the amount due. Finance charges can be applied to all amounts that are at least 30 days past due at the rate of 1.5% per month (18% annual rate). **If the account is in default and turned over for collection, I acknowledge that I will be responsible for all reasonable costs associated with effecting collection.** If during the admission or application process I have provided a cell phone number; I acknowledge that I may be contacted at that number for account servicing matters, including but not limited to collecting on my account should it become delinquent.

_____ _____

Signature **Date**

PATIENT NAME: _____

Rockwall Family Dentistry Office and Financial Policies

This is an outline of our office financial policies. We ask that you provide any/all insurance information to us upon arrival of your first visit. While we will do our very best to outline your insurance plan to you, it is ultimately your responsibility to know your insurance plan benefits and restrictions. Based upon the information given to us by your insurance plan, we will ask for co-payments accordingly. It is important to remember that your insurance policy is a contract between you and your insurance company. We will do everything possible to assist you in getting your claim paid: however, all charges incurred for your dental treatment are your sole financial responsibility. Your co-payments are an estimate only. The quotes given to our office by your insurance company are merely that. They are not a guarantee of payment to us. We ask that you pay your co-payment, deductible, or any balances at the time services are rendered. If you are unable to pay your estimated portion for that time, we ask that you make prior financial arrangements with our billing representative.

If you do not have dental insurance, by signing this statement you acknowledge that you understand that you are responsible for payment in full at the time services are rendered. If you have insurance, by signing this statement you acknowledge that your insurance company may pay less than the actual bill for services and that you are fully responsible for payment of your account. By signing this statement you agree to pay for all balances not paid by your insurance company and any legal fees incurred to enforce this statement. If a balance on any account is not paid within 30 days, you could be charged interest on that account until paid in full.

I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group benefits directly to Melina Cozby, DDS and Rockwall Family Dentistry P.A. I agree to give Rockwall Family Dentistry permission to contact me regarding appointments and/or treatment at the phone number provided. I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I certify that the information I provided here is true and correct

Signature _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date: _____

Employee Signature : _____

PATIENT NAME: _____

Photo Consent

I,_____&_____, consent Rockwall Family
NAME of Minor/Child & Guardian/Parent (PLEASE PRINT)
Dentistry and Elite to be able to use photographs and/or videos of me for marketing and/or office advertising purposes, but not limited to only these purposes. For use on their (Rockwall Family Dentistry/Elite) social media tools which may include but not limited to their (Rockwall Family Dentistry/Elite) Facebook/ Websites/ Printed Materials.

Name(PLEASE PRINT):_____

Signature:_____ Date:_____

PATIENT NAME: _____

Rockwall Family Dentistry – Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information

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Our legal duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, out legal duties and your rights concerning your health information. We must follow the privacy practices that are described in the notice while it is in effect.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by law. We reserve the right to make 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 changes. Before we make significant change in our privacy practices, we will change this notice and make the new notice available.

Uses and disclosures of health information: We use and disclose health information about you for treatment payment, and healthcare operations.

Patient Rights: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request, unless we cannot practically do so. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you $25 administration fee plus $5 per page for records.

3084 N Goliad St, Suite 124
Rockwall, TX 75087
972.772.4000