

New Patient Health History Form

Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

Part One: Tell Us About Your Child

Child's Name _____
Last First MI

Nickname _____ Male Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

Child's Home # (_____) _____

Child's Home Address: _____

City State Zip

Part Two: Mother's Information

Name _____

Stepmother Guardian Birthdate ____/____/____

Marital Status: *(Circle One)*

Single Married Separated Widowed Divorced

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Part Three: Father's Information

Name _____

Stepfather Guardian Birthdate ____/____/____

Marital Status: *(Circle One)*

Single Married Separated Widowed Divorced

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Part Four: Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

Part Five: Referral

Who may we thank for referring you to our office?

(Circle One) Website Friend _____

-or-

Dr. _____

Other _____

Part Six: Person Responsible for Account

Name: _____

Relationship _____

Billing Address _____

City State Zip

Home # (_____) _____

Work # (_____) _____

E-mail _____

Part Seven: Primary Dental Insurance

Name _____

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

CHILDREN'S DENTAL CARE OF GARLAND
KEE KWAK, DDS
2426 BELTLINE ROAD
GARLAND, TX 75044
972-530-3898

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

(You May Refuse to Sign This Acknowledgement)

____ "I acknowledge that I have received and /or been offered a copy of the Dental Materials Fact Sheet as required by law. A copy can be downloaded from the practice web site or I may request one at anytime in the future."

____ "I hereby acknowledge that I have been given the right to review this office's Notice of Privacy Practices."(HIPAA)

____ "I certify that I have read and understand the above. I affirm that the information contained in this form and any additional information that I may furnish is true and correct to the best of my knowledge. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I will not hold Dr. Kee Kwak, DDS or the staff responsible for errors or omissions that I have made in the completion of this form."

_____, have received a copy of this office's Notice of Privacy Practices.
Please Print Name

Signature *Date*

For Office Use Only _____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- ____ Individual refused to sign
 - ____ Communications barriers prohibited obtaining the acknowledgment
 - ____ An emergency situation prevented us from obtaining acknowledgment
 - ____ Other (Please specify) _____
- _____

Children's Dental Care of Garland
Kee Kwak, DDS
2426 Belt Line Rd.
Garland, TX 75044
972-530-3898

FINANCIAL POLICY & DENTAL CARE PLANS

PRIVATE PAY

All services are payable in full at the time services are rendered.

We accept cash, personal checks, credit cards: Visa, Master Card, American Express, Discover & Care Credit.

A \$30.00 charge will apply to your account for any returned checks.

We are now in-network with **most dental insurance plans.

DENTAL INSURANCE

If you have dental insurance, we will file your claims to your insurance company as a courtesy whether we are in-network or out-of network. All deductible or patient **estimated** out of pockets will be collected at the time services are rendered, as well as any procedures or services **not** covered by your insurance company.

DISCOUNT PLANS

If you have a discount plan that we are **in-network** with, the **full** amount per the discount fee schedule will be collected at the time services are rendered, as well as any services or procedures that are **not** listed under the plan. This type of plan is **not** insurance, and there will be no claims filed or payments received from the plan.

****ANY** amount quoted to you is **only an estimate** based off the benefits and percentages given to us by your insurance and are **not** a guarantee of payment by your insurance company. Any amount remaining after your insurance pays and your **estimated** amount has been collected is your responsibility, as well as any services or procedures **not** covered by your insurance company.

If your child needs treatment, our Financial Coordinator will go over the treatment plan and finances with you before any treatment is scheduled or performed. We would also be happy to answer any questions you may have about your insurance or discount plan.

I have read and understand the above information.

Signature (Parent/Guardian)

Date

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DUPLICATE COPY