Children's Dental Care of Garland

Kee Kwak, DDS
2426 Beltline Road Garland, TX 75044

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 _____

Part Eight: Dental History Health History

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

If not, how long since the last visit to the dentist?_____

_____

Date last x-rays taken? _____

Have there been any injuries to the teeth, face or mouth?

_____

Has your child had an unhappy experience at the dentist?

If yes, please explain _____

_____

What procedures has your child had?

Laughing Gas Y N Numbing Y N

Why did you bring the child to the dentist today?_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting

Y N Nail Biting

Y N Bottle / Sippy Cup

Y N Pacifier

Y N Thumb / Finger Sucking

Y N Chewing Objects/Grinding

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Does child drink tap water? Yes No

Is the child using fluoride rinses? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Part Nine: Health History

Has the child ever had any of the following conditions?

Y N Current w/ Immunizations?

Y N Handicaps/Disabilities

Y N Allergies to any Drugs

Y N Heart Disease / Murmur

Y N Any Operations / Surgery

Y N Hemophilia/Blood disorder

Y N Congenital Birth Defects

Y N Kidney/Liver Conditions

Y N Rheumatic/Scarlet Fever

Y N Allergies to Latex Product

Y N Sickle Cell Trait/Disease

Y N Abnormal Blood Pressure

Y N Seizures/Fainting

Y N Pregnancy

Y N Cancer

Y N Hepatitis

Y N Asthma

Y N Tuberculosis

Y N Sight Impairment

Y N Abnormal Bleeding

Y N Hearing Impairment

Y N Convulsions/Epilepsy

Y N Diabetes / Endocrine

Y N Developmental Delays

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____)_____

Is the child currently under the care of a physician? Y N

Please describe the child's current physical health:

Good Fair Poor

Part Ten: Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist 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 payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize the dental staff to perform the necessary dental service my child may need. This consent shall remain in full force and effect until cancelled by either party.

_____ _____

Signature of Parent or Guardian *Date*

(The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.)

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) _____

_____

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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