Dear Parent:

We welcome you to our office and want to assure you that our office staff will do everything possible to make your child’s first dental visit a happy dental experience.

During the first visit, we generally perform a thorough oral examination including x-rays plus a cleaning and fluoride treatment. We usually do not provide restorative treatment during the first visit. A discussion with the parent will follow the examination.

In order to develop trust and the best possible relationship between your child and our dental staff, parents are not permitted in the treatment room unless specifically invited by the doctor. Please do not be upset if your child cries. Crying is a normal reaction to anything new and strange. Give your child the opportunity to build confidence and communication with his/her dentist. This will help to eliminate dental fears. It is important to reinforce your child with positive thinking through the use of specific words. Never mention the following words when referring to his/her visit: “hurt”, “painful”, “shot”, “needle”, “pull teeth”. Instead, use words and phrases such as “pictures of teeth”, “sleeping juice”, “clean your teeth”. Please do not promise your child that they will not experience discomfort. Instead, let us inform your child how he/she might feel throughout the treatment.

In order to be able to offer you the best possible dental service, we request your complete cooperation in observing the following rules:

1. Punctuality to your dental appointment.
2. If you need to cancel your appointment, please do so 24 hours in advance.
3. Before the end of the treatment, confirm the date and hour of your next appointment. If you do not have a telephone, please give us your nearest relative or friend’s telephone number to confirm your appointment.
4. After two no show-ups or two cancellations, we will be obligated to discontinue treatment.
5. It is important that you follow proper home oral hygiene, diet and special instructions in order to obtain the best possible long-term results.

We appreciate your confidence in allowing us to offer our best possible dental care to your child.

Signature: ___________________________________________ Date: __________
Casey R. Frazier, DDS
100 Medical Center Pkwy, Suite 700
Huntsville, TX 77340
(936)291-2276

Patient Information

*It is important that you complete all of the following information before any services are rendered.*

Date: _________/_______/_______

Patient Name: ___________________________ Nick Name: __________ Age: ______ DOB: ______/_____/______

Sex: _________ Race: __________ Siblings/Pets/Hobbies: __________________________

Mailing Address: __________________________________________________________________________
City: __________________ State: ______ Zip: ______

Telephone #: __________________ To Whom May We Thank for referring you: __________________________

Guarantor Information:

Father’s Name: ___________________________ Social Security #: __________ DL#: ______ DOB: ______
Mailing Address: __________________________________________________________________________
City: __________________ State: ______ Zip: ______

Employer Name: ___________________________ Occupation __________ Employer Address: __________
Phone: __________________

Marital Status: __________ If divorced or separated, has this happened recently? (6 months) Yes ______ No ______

Mother’s Name: ___________________________ Social Security #: __________ DL#: ______ DOB: ______
Mailing Address: __________________________________________________________________________
City: __________________ State: ______ Zip: ______

Employer Name: ___________________________ Occupation __________ Employer Address: __________
Phone: __________________

Marital Status: __________ If divorced or separated, has this happened recently? (6 months) Yes ______ No ______

Legal Guardian if other than Parent:

Name: ___________________________ Social Security #: __________ DL#: ______ DOB: ______
Mailing Address: __________________________________________________________________________
City: __________________ State: ______ Zip: ______

Employer Name: ___________________________ Occupation __________ Employer Address: __________
Phone: __________________

Financial Information: Insurance or Private Pay? __________

Insurance Information:

Insurance Name: ___________________________ Policy #: __________ Group #: __________
Mailing Address: __________________________________________________________________________
City: __________________ State: ______ Zip: ______

Phone #: __________________ Subscriber Name: __________________

Emergency Contact Other than Parents: ___________________________ Phone #: __________________

I authorize Dr. Casey Frazier 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 payor and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual/estimated bill for services. I also understand that I am responsible for any and all charges not paid by my insurance carrier.

Parent Signature: ___________________________ Date: ______/_____/_______
Health Questionnaire

Name: ____________________________ Age: _______ Sex: _______ Birth Date: _____________

Address: __________________________ Telephone: __________________________

Date of last physical exam: _____________ Physician’s Name: __________________________

1. Is your child under treatment by a physician?    Yes    No

2. Is your child taking any medicine now? _______ _______

3. Has your child ever been seriously sick? _______ _______

4. Has your child ever been hospitalized? _______ _______

5. Did your child have a history of health problems at birth or during initial years? _______ _______

6. Have you been told by a physician that your child has a heart murmur? _______ _______

7. Does your child suffer from asthma or hay fever? _______ _______

8. Is your child physically or mentally handicapped? _______ _______

9. When your child scratches or cuts him/herself, does he/she stop bleeding promptly? _______ _______

10. Has your child ever experienced an allergic reaction to latex? _______ _______

11. Has your child ever had a history of blood transfusion? Date: _______ _______

12. Has your child ever had a history of the following: If “YES”, please check the appropriate space and write the date(s).

   - Rheumatic Fever
   - Severe Headaches
   - Thyroid Disease
   - Rheumatoid Arthritis
   - Congenital Birth Defects
   - AIDS/HIV
   - Jaundice, Hepatitis
   - Heart Trouble
   - Eye Problems
   - Diabetes
   - Kidney or Liver Problems
   - Ear Problems
   - Tuberculosis
   - Convulsions, Epilepsy
   - Nervous Disorders
   - Respiratory Problems
   - Measles
   - Cancer
   - Gastrointestinal Problems
   - Bleeding Disorders
   - Depression
   - Scarlet Fever
   - Bronchitis

13. Has your child ever experienced an unusual reaction (allergy or sensitization) to any of the following medicines?

   - Aspirin
   - Dental Local Anesthetics (to put teeth asleep)
   - Sulfonamide (Sulfa)
   - Penicillin
   - Other medicines (remarks___________)
   - Cortisone (steroids)
   - Codeine
   - Erythromycin

14. Do you think your child will be a cooperative patient? _______ _______

15. Does your child have problems: _______ Concentrating _______ Learning _______ Cooperating _______

DENTAL HISTORY

1. Is this your child’s first visit to the dentist? _______ Yes _______ No

2. If no, date of last examination

3. What is the purpose of this visit today?

4. Is there a history of missing teeth in the family? _______ Yes _______ No

5. Does your child have a speech problem? _______ Yes _______ No

6. Does your child take fluoride supplements? _______ Yes _______ No

7. Has your child ever had any of the following?

   - Abscess (gum boils)
   - Injury to front teeth
   - Toothache
   - Bleeding Gums
   - Stained teeth
   - Frequent sore throats
   - Bad breath
   - Cold sores (fever blisters)

8. Does your child present any of the following habits?

   - Mouth Breathing
   - Thumb Sucking
   - Grinding, clenching teeth

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 the dental office of any changes in my child’s medical status.

Parent/Guardian Signature: ____________________________ Relation to Child: ____________________________ Date: _____________
ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES
**You May Refuse to Sign This Acknowledgement**

I, _________________________, have received a copy of this office’s Notice of Privacy Practices.

{Please Print Patient’s Name}

{Signature of Parent or Guardian}

{Date}

For Office Use Only

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

• Individual refused to sign
• Communications barriers prohibited obtaining the acknowledgement
• An emergency situation prevented us from obtaining acknowledgement
• Other (Please Specify)

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