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.

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:** ____/____/_____

Casey R. Frazier, DDS
Pediatric Dentistry, P.C.
100 Medical Center Parkway, Suite 700
Huntsville, TX 77340
(936) 291-2276

Health Questionnaire

Name:_____ **Age:**_____ **Sex:**_____ **Birth Date:** _____
Address:_____ **Telephone:**_____
Date of last physical exam:_____ **Physician's Name:**_____

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

{**Casey R. Frazier, DDS**}

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)