Bunker Hill Pediatric Dentistry, PLLC
Welcome To Our Practice!

We want to welcome your child into our practice. Our goal is to make his/her dental experience pleasant and educational. Please provide us with all information requested so that we can better understand and care for your child.

Date: _____

Patient Name: _____ Nickname: _____ Sex: _____
Last First MI
Birthday: _____ Age: _____ SSN: _____

Siblings & Ages: _____

Home #: _____ Cell #: _____ School: _____ Grade: _____ Weight: _____

Child's Address: _____
Street Apt No.
_____
City State Zip
Reason for visit: _____

Health Information
Has your child ever had difficulty with any of the following: (Please check all that apply)

___ ADHD	___Cerebral Palsy	___ Kidney Disorder	___ Rheumatic Fever
___ AIDS/HIV	___Chicken Pox	___Liver Disorder	___Sinus Problems
___Anemia	___Convulsions	___Lung Disease	___Thyroid Disorders
___Asthma	___Diabetes	___ Measles/Mumps	___Tuberculosis
___Bladder Disease	___Epilepsy	___ Mental Retardation	___Vision Disorders
___Blood Transfusions	___Hearing Disorders	___ Mononucleosis	___Behavioral Problems
___Bleeding Disorders	___Heart Condition	___Pregnancy	___Emotional Problems
___Cancer	___Hepatitis	___Respiratory Problems	___Other

Please describe all above conditions that apply: _____

	Yes	No
Is your child in good health?	____	____
Are immunizations up-to-date?	____	____
Is your child taking any medicines or drugs:	____	____
Has your child ever been hospitalized or had surgery?	____	____
Does your child have a heart murmur or condition requiring? Prophylactic Antibiotic coverage before dental treatment	____	____
Does your child have any allergies (drugs or latex)	____	____

If yes, please specify: _____

Child's Pediatrician: _____ Last Visit: _____ Phone: _____
Has your child been seen by another dentist?_____ If yes, name:_____
Date of last visit:_____ Phone: _____ X-rays: _____
Has your child ever had an unfavorable dental experience?_____
How often does your child brush (i.e. once per day, twice per day): _____
Who is responsible for teeth cleaning? _____Child _____Parent _____Both
Was your child breast fed? _____ Bottle fed? _____ Age discontinued? _____
Does your child: (Please check all that apply)
___Suck thumb/Finger ___Suck/Bite lips ___Grind teeth ___Pacifier
___Bite/Chew nails ___Chew hard objects ___Clench jaw
What is your home water source? ___Public System _____ Private Well ____Other _____

Because your child is a minor, it is necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment is performed. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate there to. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefits be denied.

Signature of Parent of Guardian: _____ Date: _____

Office Use
I verbally reviewed the medical/dental information above with the parent/guardian regarding the patient named herein. Initials _____ Date _____

Bunker Hill Pediatric Dentistry, PLLC

Who is Accompanying the Child today?

Name: _____ Relationship: _____
Do you have legal custody of this child? _____ Is your child adopted? _____
Child lives with: _____Both Parents _____Mom _____Dad _____Grandparent _____Guardian

I have listed below two persons who might be involved in his/her dental updates and/or transportation.
1. _____ 2. _____

Parent (or Guardian) Information

Father's Name: _____
DOB: _____SSN: _____
Home address if different from child:
_____
_____
Home #: _____
Work #: _____
Cell/Pager #:_____
E-mail: _____
Employer:_____
Occupation:_____
Marital Status: ___Single ___Married ___Divorced___Widowed

Mother's Name: _____
DOB: _____ SSN: _____
Home address if different from child:
_____
_____
Home #: _____
Work #:_____
Cell/Pager #:_____
E-mail: _____
Employer:_____
Occupation:_____
Marital Status: ___Single ___Married ___Divorced ___Widowed

Emergency Information

Name: _____ Relationship: _____ Phone: _____

Person Responsible for Account

Name: _____ Relationship: _____
Billing Address: _____
Home Phone: _____ Work: _____ Cell: _____
DL#: _____ SSN#: _____

Primary Insurance Information

Name of Insured: _____
Insured Date of Birth: _____ ID No. _____Group No._____
Insured's Address: _____
Insured's Employer Name: _____
Employer Address: _____
Patients relationship to insured: _____Self _____Spouse _____Child ___ Other _____
Insurance Plan Name: _____ Phone#: _____
Insurance Plan Address: _____

Referral Information – Who can we thank for referring you to our office?

_____Another Patient _____Dental Office _____ Pediatrician _____ Yellow Pages _____Website/Internet _____School _____Work

Other/Name of Patient, Office, or Pediatrician Referral: _____

I authorize the dentist to release any information to third party payers and /or other health practitioners, if necessary. I authorize and request my insurance company to pay directly to the dentist benefits otherwise payable to me.

Signature of Parent of Guardian: _____ Date: _____

Office Use

I verbally reviewed the medical/dental information above with the parent/guardian regarding the patient named herein. Initials _____ Date _____

Bunker Hill Pediatric Dentistry, PLLC
General Informed Consent

Bunker Hill Pediatric Dentistry's goal is to provide complete oral health and create a comfortable environment for our young patients. We are committed to providing a safe and pleasant dental experience.

Our policy is to inform the parent/guardian before we perform any procedures and obtain verbal and written consent. The initial visit includes: a comprehensive clinical examination, diagnostic x-rays, a thorough dental cleaning, and preventive fluoride treatment. The Periodic 3 or 6 month recare visit thereafter includes cleaning, exam any needed radiographs and fluoride.

If further dental treatment is needed, we put together a complete dental treatment plan with the recommended procedures and alternatives. Treatment procedures may include, but are not limited to: local anesthesia, controlled nitrous oxide-oxygen sedation ("laughing gas"), dental restorations, nerve treatment, crowns, extractions, and space maintainers. The Doctor will inform you of all treatment options, the risks and benefits of each, and the recommended treatment of choice for your child.

Pediatric dentistry differs from general dentistry in that with treating children, behavior dictates treatment. To obtain your child's cooperative, we practice a few behavior management techniques such as: the "tell-show-do" method, modeling, distraction, positive and negative reinforcement, passive stabilization, and voice control. Pharmacologic behavior management is also offered if these methods are unsuccessful.

If your child requires operative treatment/dental restorations, there exist some associated risks. These occur very rarely and include, but not limited to: numbness, sore gums, pain, infection, swelling, bleeding, bruising, discoloration, nausea, vomiting, allergic reactions, and aspiration or swallowing of a foreign object.

It is imperative that your child arrives promptly for all pre-scheduled appointments. We have reserved a time that has been dedicated for your child. If you are unable to arrive on time or if you need to reschedule an appointment, please contact us as early as possible.

If you have any questions regarding the information presented here, or any other aspect of our dental philosophy or patient management, please do not hesitate to ask us.

The signature of a parent or a guardian below authorizes the completion of all agreed upon dental procedures and the use of agreed upon methods. This consent shall remain in full force until cancelled by either party. Thank you in advance for your cooperation.

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by Dr. Luu or her supervised staff for diagnostic purposes and dental treatment of my child in my absence.

_____ _____

Printed Patient's Name Printed name of parent or guardian

_____ _____

Patient's Age Signature of parent or guardian

_____ _____

Todays date Your relationship to patient

_____

Witness 'Signature

Bunker Hill Pediatric Dentistry, PLLC

9742 Katy Freeway, Suite 500
Houston, TX 77055
713-464-KIDS (5437)

Financial Policy

We welcome you to our practice and thank you for choosing Bunker Hill Pediatric Dentistry for your child's dental needs. We strive to provide the best dental experience and oral health care for your child. It is our policy to make definite financial arrangements with you, the parent or legal guardian, before any treatment begins on your child. Our policy is outlined below. Please do not hesitate to ask any questions.

1. Payment is due in full at the time services are rendered. We accept cash, personal checks, debit cards, and most major credit cards (MasterCard, VISA, American Express, and Discover). If an extended payment plan is sought, we offer financing through the CareCredit program.
2. Payment is due in full at the time of the appointment for all new patient emergency visits.
3. All services rendered are charged directly to the parent or legal guardian of the patient, and the legal guardian is ultimately responsible for the account regardless of insurance coverage.
4. If you suspend or terminate dental care at Bunker Hill Pediatric Dentistry, PLLC, any fees for services rendered will be immediately due and payable.

Regarding dental insurance

5. You must provide us with accurate dental insurance information with the correct mailing address or a dental claim form provided by your employer.
6. As a courtesy to our patients, if we have received all your insurance information on the day of the appointment, we will gladly file the insurance claim for you.
7. You must be familiar with your insurance benefits. We are not responsible for and do not guarantee how your insurance company processes your claims or what benefits they pay per claim. You will be responsible for the deductible and the estimated portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. **You are responsible for paying all charges not covered by your insurance, including all fees above your insurance company's schedule of "allowable" or usual and customary "UCR" fees.** If you have questions about "UCR" fees, please ask.
8. Your insurance benefits are assigned to you, the patient, and is a contract between you and your employer. Your coverage amount depends on the quality of the plan purchased by your employer, not the fees of the practice.
9. By law your insurance company is required to pay each claim within 30 days of receipt. We file all insurance electronically, so your insurance company will receive each claim within days of the treatment.
10. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. Further insurance appeal will become your responsibility. We will gladly provide you with a claim form to assist you in following up with your insurance claim.
11. 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 total amount due. If you have not paid your balance within 60 days, finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate) until paid. If the account is in default and turned over for collection, a collection fee will be added. We will be glad to send a refund to you if your insurance pays us.
12. **There will be a $30.00 service charge for all returned checks.**
13. We value your time and appreciate patients who honor their scheduled appointments. **There will be a $35.00 fee charged to parents that cancel with less than 24 hours of notice.**

Authorization

I have read and accept the above Financial Policy for Bunker Hill Pediatric Dentistry. I understand it and agree to the terms set forth regarding payment.

_____	_____	_____
Print Name of Responsible Party	Signature of Responsible Party	Date
_____	_____	
Patient	Relationship to Patient	

9742 Katy Freeway Suite 500
Houston, TX 77055
713-464-5437
713-464-5438 (fax)

BROKEN APPOINTMENT CHARGE

We reserve space in our office for you and your family to receive care. Should you need to break your appointment, please let us know at least 24 hours in advance.

If an appointment is broken without advance notice, a $35.00 broken appointment fee will be assigned to your account. This is not covered through your insurance. This fee will become due as a part of your accounts balance, and it will need to be satisfied prior to scheduling future appointments.

Kindly give us notification so your appointment time can be given to another patient.

Thank you for your cooperation.

_____
Printed Patient's Name

_____
Patient's Age

_____
Witness' Signature

_____
Today's Date

_____
Your Signature

_____
Your Printed Name

_____
Your Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

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

_____
Please Print Name

_____
Signature

_____
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)

_____

_____

_____