



Thank you for selecting Wonderland Pediatric Dentistry! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

***Please share with us how you were referred:** _____

Your Child		
Child's Name:		
Nickname:	Sex:	
Birthdate:	Age:	
SS#/SIN:		
School:		
Child's Home Address:		
City:	St:	Zip:
Responsible Party		
Name:		
Relationship:		
Address:		
City:	St:	Zip:
Email:		
Phone: (Home)	(Other)	
SS#:	DOB#:	

Primary Insurance		Secondary Insurance	
Insured's Name:		Insured's Name:	
Relationship:		Relationship:	
Birthdate:	SSN/SIN#:	Birthdate:	SSN/SIN#:
Employer:	DOH:	Employer:	DOH:
Occupation:		Occupation:	
Insurance Company:		Insurance Company:	
Group #:	Subscriber ID #:	Group # :	Subscriber ID #:
Ins Co Address:		Ins Co Address:	
City:	St:	Zip:	City:
			St:
			Zip:

Please Turn Over

NAME:

AGE:

DENTAL HISTORY (CONFIDENTIAL)

Medications and your child's overall health have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Previous Dentist: _____ Phone: _____

Address: _____

City: _____ State/Prov: _____ Zip/PC: _____

Date of last dental visit: _____

Were x-rays taken? Yes Type: _____ No

Has your child had difficulty with previous dental visits? Yes Please Explain: _____ No

Are you aware of any problems with your child's mouth or teeth? Yes Please Explain: _____ No

Has your child ever pre-medicated for dental treatment? Yes Please Explain: _____ No

Has your child injured head, mouth, or teeth? Yes Please Explain: _____ No

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child have a history of, or is your child currently doing any of the following?

Pacifier Yes No

Suck Thumb/Finger Yes No

Suck/Bite Lip Yes No

Bite/Chew Nails Yes No

Chew Hard Objects (pencils, etc.) Yes No

Grind Teeth Yes No

Was your child Yes No

Bottle Fed Yes When weaned: _____ No

Breast Fed Yes When weaned: _____ No

MEDICAL HISTORY (CONFIDENTIAL)

Physician's Name: _____ Phone #: _____

Date of Last Visit: _____

Previous Hospitalizations/ Surgeries/ Serious Illnesses: _____ When? _____

Had a Blood Transfusion Yes When: _____ No

Are immunizations up to date Yes No

Is your child taking any Medications: Yes Which Ones: _____ No

Is your child Allergic to any medications? Yes Which Ones: _____ No

Has your child ever developed any condition including bleeding, drug or anesthesia reaction or rash requiring special treatment after your last dental visit? Yes Please Explain: _____ No

HEALTH HISTORY (CONFIDENTIAL)

Does your child have a Blood Disorder?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
Anemia	<input type="checkbox"/> Yes			Von Willebrand	<input type="checkbox"/> Yes	
Hemophilia	<input type="checkbox"/> Yes			Sickle Cell	<input type="checkbox"/> Yes	
Excessive Bleeding	<input type="checkbox"/> Yes					

If you answered yes to any of these, please explain: _____

Does your child have a Heart Condition?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
Artificial Valve	<input type="checkbox"/> Yes			High Blood Pressure	<input type="checkbox"/> Yes	
Congenital Heart Defect	<input type="checkbox"/> Yes			Low Blood Pressure	<input type="checkbox"/> Yes	
Heart Disease	<input type="checkbox"/> Yes			Heart Attack (Myocardial Infarction)	<input type="checkbox"/> Yes	
Heart Murmur (Irregular Heart Beat)	<input type="checkbox"/> Yes			Pacemaker	<input type="checkbox"/> Yes	
Rheumatic Fever	<input type="checkbox"/> Yes			Infective Endocarditis	<input type="checkbox"/> Yes	
Angina (Chest Pains)	<input type="checkbox"/> Yes			Mitral Valve Prolapse	<input type="checkbox"/> Yes	

If you answered yes to any of these, please explain: _____

Does your child have a Respiratory Diseases/ Lung Disorder?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
Asthma	<input type="checkbox"/> Yes			Persistent Cough	<input type="checkbox"/> Yes	
Breathing Difficulty	<input type="checkbox"/> Yes			Shortness of Breath	<input type="checkbox"/> Yes	
COPD	<input type="checkbox"/> Yes			Sleep Apnea	<input type="checkbox"/> Yes	

If you answered yes to any of these, please explain: _____

Does your child have Special Needs?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
ADHD	<input type="checkbox"/> Yes			Wheelchair	<input type="checkbox"/> Yes	
Behavior Disorder	<input type="checkbox"/> Yes			Hearing Impairment	<input type="checkbox"/> Yes	
Autism	<input type="checkbox"/> Yes			Head Injury	<input type="checkbox"/> Yes	
Depression	<input type="checkbox"/> Yes			Developmental Challenges	<input type="checkbox"/> Yes	
Down Syndrome	<input type="checkbox"/> Yes			Nervous Disorders	<input type="checkbox"/> Yes	
Cerebral Palsy	<input type="checkbox"/> Yes			Psychological Disorders	<input type="checkbox"/> Yes	
Vision Impairment	<input type="checkbox"/> Yes			Bipolar Depression	<input type="checkbox"/> Yes	
Spina Bifida	<input type="checkbox"/> Yes					

If you answered yes to any of these, please explain: _____

Cont. HEALTH HISTORY (CONFIDENTIAL)

Does your child have an Infectious Disease?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
HIV/AIDS	<input type="checkbox"/> Yes				STD	<input type="checkbox"/> Yes
Hepatitis	<input type="checkbox"/> Yes				Tuberculosis	<input type="checkbox"/> Yes
Herpes	<input type="checkbox"/> Yes					

If you answered yes to any of these, please explain: _____

Does your child have Stomach Problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
Reflux	<input type="checkbox"/> Yes				Ulcers	<input type="checkbox"/> Yes

If you answered yes to any of these, please explain: _____

Does your child have Ear Problems?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
Ear Tubes	<input type="checkbox"/> Yes				Recurrent Ear Infections	<input type="checkbox"/> Yes
Hearing Loss	<input type="checkbox"/> Yes					

If you answered yes to any of these, please explain: _____

Does your child have/ had Cancer?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
Chemotherapy	<input type="checkbox"/> Yes				Remission	<input type="checkbox"/> Yes
Radiation	<input type="checkbox"/> Yes				Leukemia	<input type="checkbox"/> Yes
Tumors	<input type="checkbox"/> Yes				How Long?	

If you answered yes to any of these, please explain: _____

Does your child have history of any of the conditions listed below?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	If you chose yes, please check the box that applies.	
Arthritis/Rheumatism	<input type="checkbox"/> Yes				Liver Disease	<input type="checkbox"/> Yes
Cleft Palate	<input type="checkbox"/> Yes				Pregnancy	<input type="checkbox"/> Yes
Diabetes	<input type="checkbox"/> Yes				Seizures	<input type="checkbox"/> Yes
Dialysis	<input type="checkbox"/> Yes				Sinus Problems	<input type="checkbox"/> Yes
Epilepsy	<input type="checkbox"/> Yes				Stroke	<input type="checkbox"/> Yes
Dizziness/Fainting	<input type="checkbox"/> Yes				Tobacco Use	<input type="checkbox"/> Yes
Joint Replacement	<input type="checkbox"/> Yes				Drug Use	<input type="checkbox"/> Yes
Kidney Disease	<input type="checkbox"/> Yes				Eating Disorder	<input type="checkbox"/> Yes
Thyroid Disorder	<input type="checkbox"/> Yes				Skin Rash	Yes
					Artificial Joint	<input type="checkbox"/> Yes

If you answered yes to any of these, please explain: _____

Does your child have anything that has not been previously mentioned?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If you answered yes, please explain: _____



Wonderland Pediatric Dentistry

AUTHORIZATION FOR CARE & TREATMENT: I hereby agree that Wonderland Pediatric Dentistry may perform care and treatment, and may conduct such examinations, laboratory tests and procedures (including x-rays), administer such local anesthetics, analgesia, medication and treatment, as may be directed by my treating practitioner. I acknowledge that no guarantees have been made to me as to the effect of such examinations, tests, procedures or treatment of my condition.

I certify that I have read and understand the above. I acknowledge that my questions, if any about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I have made in the completions of this form.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I consent to the use and disclosure of my Protected Health Information by Wonderland Pediatric Dentistry for purposes of treatment, payment, and health care operations. For example, my treating practitioner at Wonderland Pediatric Dentistry may furnish Protected Health Information maintained by Wonderland Pediatric Dentistry in the course of my care and treatment. Also, as Wonderland Pediatric Dentistry is a teaching practice, I consent to the use and disclosure of my Protected Health Information (i) for training and educational purposes to faculty dentists, residents, and dental students in health-related professions from local colleges and universities affiliated with Wonderland Pediatric Dentistry, and (ii) for review in preparation for possible research. Release of medical records and information will be made according to state and federal regulations. I understand that Wonderland Pediatric Dentistry may release medical information to any third party, including my employer, which may be responsible for payment of my hospital and medical expenses. (Release of medical information to employers is limited to those employers who are directly liable for the costs of the patient's health care benefits through an employer self-insured group health plan or worker's compensation, or in other circumstances in which such disclosure is legally allowed).

INSURANCE AUTHORIZATION: I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain services in order for my insurance company to pay for those services and I understand that I may be personally responsible for payment if I do not obtain any necessary prior authorization or my insurance benefits are denied, reduced, or terminated.

ASSIGNMENT OF BENEFITS, INSURANCE PROCEEDS, and SETTLEMENTS: If I am entitled to health care services under any insurance policy from any person or organization which may become liable to me to provide such benefits, I assign such benefits to Wonderland Pediatric Dentistry and practitioners employed by the practice who render such services to me. I further authorize payment directly to Wonderland Pediatric Dentistry and such practitioners of all such insurance benefits payable to me. Such insurance may include, but is not limited to, private commercial insurance, auto liability insurance, worker's compensation, programs such as Medicare and Medicaid, or other government sources.

I certify that the information given regarding my insurance is accurate and current to the best of my knowledge.

I further assign to Wonderland Pediatric Dentistry any payments for medical benefits payable to me as a result of any settlement or judgment in a lawsuit.

FINANCIAL AGREEMENT: In consideration for services rendered by Wonderland Pediatric Dentistry and practitioners employed by Wonderland Pediatric Dentistry, I guarantee prompt payment of all such services not paid by insurance carriers or third parties within thirty (30) days. I understand that any amount not covered by my insurance carrier or other third party payer is my person responsibility, and I agree to make payments for any such amount. If Wonderland Pediatric Dentistry does not receive such payment within thirty (30) days from the date such balance is due, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collection cost including attorney's fees and/or collection fees in addition to the payment owed. I give Wonderland Pediatric Dentistry the right to examine my consumer credit report for financial information relation to my responsibility to pay for medical services.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that I have received the Wonderland Pediatric Dentistry Health Notice of Privacy Practices. A copy is available upon request.

PHOTOS AND VIDEO: Please note, to protect the privacy of our staff and other patients, we would ask that you refrain from taking any forms of photography or videography in our offices. Should you like a photo of your visit to the dentist, please ask a staff member. He/she will attempt to accommodate your request.

DISCLOSURE TO FAMILY OR FRIENDS INVOLVED IN MY CARE: I understand that I may limit the disclosure of my health information to family members, or other close relatives or close personal friends by notifying a member of the staff assigned to care for me.

I have read all the above statements and accept the terms and conditions as stated.

Patient/Parent/Agent/Guardian Signature

Witness Signature

Date

Interpreter (if used) Signature

Witness Signature

Date



This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (281) 373-5437.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Wonderland Pediatric Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. *Safeguarding Your Personal and Health*

Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Wonderland Pediatric Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Dr. Bui.

As of September 1, 2008 the State of Texas requires that anyone who is prescribed a controlled substance (narcotic) will have their information entered into a nationwide database. The Drug Prescription Monitoring database is very secure, as only physicians and law enforcement can access the database. If you do not wish to have your information entered into this database, please inform the doctor and he will prescribe you a non-narcotic. If you have any questions, you can contact the Texas Department of Public Safety by calling (512) 424-7293.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Wonderland Pediatric Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I _____ have reviewed.

Signed _____ Date _____