We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with your child.

Patient Information

Child's Name_____ Preferred Name_____ Soc. Sec.# _____
Last Name First Name Initial

Address_____

City _____ State_____ Zip_____ Home Phone _____

Cell Phone _____ Email _____

Sex M / F Age _____ Birthday _____ School_____

Grade _____ Hobbies/Sports _____

Child's pets _____

Names of siblings _____

Whom may we thank for referring you?_____

Notify in case of emergency? _____

Responsible Party

Person Responsible for Account _____
Last Name First Name Initial

Relation to child _____ Birthday _____ Soc. Sec. # _____

Address (if different from child) _____

City _____ State _____ Zip_____Home Phone _____

Cell Phone _____Email_____

Person Responsible Employed by _____ Occupation _____

Business Phone _____ Business Email _____

Insurance Company _____ Phone _____

Subscriber # _____ Group # _____

Please complete both sides.

Dental History

What would you like us to do for you today?_____

Former Dentist_____ Address_____

Phone _____ Date of last dental care_____ Date of last x-rays_____

How often does your child brush? _____ Floss_____

Does your child experience pain or discomfort in the jaw joint? Yes / No
Has your child ever experienced mouth or chin injury? Yes / No
Does your child have speech problems? Yes / No
Has your child experienced an adverse reaction during or in conjunction with a medical or dental procedure? Yes / No

Child's habits affecting the mouth or teeth: Thumb sucking Nail biting Other_____
Other information about your child's dental health or previous treatment_____
_____

Medical History

Child's Physician_____ Phone _____ Last Visit Date_____
Has your child had any serious illness or operations? Y / N
If yes, describe _____
Is your child currently under physician care? Y / N
If yes, describe _____
List medications your child is taking_____
List drug allergies if any_____
Has your child had blood transfusion? Y /N If yes, give approximate dates_____

Circle Yes or No - whether your child has had any of the following:

Y/N AIDS/HIV Positive	Y/N Cough up blood	Y/N Hemophilia/ Abnormal bleeding	Y/N Shortness of breath
Y/N Anemia	Y/N Diabetes	Y/N Immunizations current	Y/N Sinus problems
Y/N Asthma	Y/N ADD/ADHD	Y/N Kidney disease or malfunction	Y/N Skin rash
Y/N Atopic(allergy prone)	Y/N Fainting	Y/N Liver disease	Y/N Spina Bifida
Y/N Autistic	Y/N Food Allergies(Nuts)	Y/N Material allergies (**Latex**, wood, metal, chemicals)	Y/N Thyroid disease or malfunction
Y/N Cancer	Y/N Hearing Impairment	Y/N Penicillin allergy	Y/N Tonsillitis
Y/N Chicken Pox	Y/N Heart Problems Heart murmur	Y/N Respiratory disease	Y/N Tuberculosis
Y/N Convulsions/Epilepsy/ Seizures Describe _____		Y/N Rheumatic/Scarlet fever	Y/N Other _____

Authorization

I have reviewed the information on this questionnaire, and it is to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all the insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature_____**Date**_____

Payment is due in full at the time of treatment, unless prior arrangements have been approved

GREENWAY
PEDIATRIC DENTISTRY

MICHAEL POSADA OROZCO DMD, MSD

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.
- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
- We require you to pay the co-payment, which is the amount not covered by your insurance company, at the time we provide service to you or your child.
- Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
- Our office does not guarantee that your insurance company will pay for treatment you receive from our practice/ We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____ _____

Signature of Patient/Responsible Party **Date**

Greenway Pediatric Dentistry

2990 Richmond Ave, Suite 170, Houston, Texas 77098 (000) 000-0000

GREENWAY
PEDIATRIC DENTISTRY

Office and Financial Policy

Insurance: We are currently a contracted dentist for many insurance plans. However, when making an appointment, it is your responsibility to confirm with your insurance company whether we are in or out of network. We will gladly file claims on your behalf and collect estimated co-pays at the time of your visit. You will be responsible for any remaining balance after your insurance has paid.

Self-pay: If you do not have insurance, payments in full is expected at the time of service.

The patient is responsible for knowing their insurance benefits coverage. We try very hard to be familiar with your insurance. It is automatically your responsibility to know your claim history and frequency limitation stated by your insurance company.

Check-in: Please arrive for your appointment at least 15 minutes prior to our appointment time, so that all paper work may be completed before you are scheduled to be seen. Please also bring your current insurance card with you to EACH VISIT. Without the insurance card, we will be unable to file your insurance, and you will be responsible for the day. On Follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up-to-date.

Check-out: Please be prepared to pay for current visits as well as any past due balances account. Payment of co-pays, deductible fees for non-covered services will be required at the time of service. For your convenience we take cash, check, MasterCard, visa, American Express and Discover.

Dishonored Checks: A $30.00 service charge will be assessed on all dishonored checks. The full amount of the check plus a $30.00 fee must be paid by either cash or money order with in ten days. If payment is not received with in the allotted ten days, your information will be filed with the Fort Bend County Attorney's Hot Check Division. All fines associated with the filling of this check will bne responsibility of the patient.

Late arrivals: We do our best to keep to the schedule. When a patient arrives late, it is impossible to stay on schedule. If you are arriving more than 15 minutes past your appointment time, you may be rescheduled so that other patients are not inconvenienced.

Late cancellation or no show for appointments: Our appointment time are very important to help accommodate everyone. Therefore, we request 24-hour notice if you need to cancel or reschedule an appointment. We will send out a written notice if you miss one appointment.

I have read, understand and agree to the above office and financial policies. I hereby attest that I have given and agree to provide current demographic and insurance information and authorize release of authorization necessary to filing and pre-certification by signing this statement.

Patient Name: _____ _____

Signature of Parent Guardian

HIPAA CONSENT

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

- Obtain payment from third-party payers for my health care services

- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient's Name: _____

Guardian's Name: _____

_____ _____

Guardian's Signature **Date**

GREENWAY
PEDIATRIC DENTISTRY

Authorization – Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). **The person bringing your child will need to present a photo identification at time of service.**

This authorization gives the person permission to bring your child in, speak to the doctor, given authorization for treatment, vaccinations, medication, certain procedures and make general health decisions.

I, _____, give the person(s) listed below permission to bring my child to GREENWAY PEDIATRIC DENTISTRY (GWPD) and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the GWPD provider. I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: _____ DOB: _____

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Name of Person (allowed to bring child) Relationship

_____ _____
Signature (Parent/Guardian) **Date**