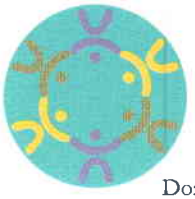

# Barefield
## Pediatric Dentistry

Donna J. Barefield, DDS, MSD & Associates

## Patient Registration Form

**Patient Information**

**Please fill out completely**

Patient Name: _____ Date of Birth: _____

Address: _____ Sex: Male ☐ Female ☐

_____

**Parent/ Guardian information**

Parents Name: _____ Date of Birth: _____

Home#: _____

Cell#: _____

E- Mail Address: _____ SSN#: _____

Driver License#: _____

Employer: _____

Work Address: _____ Work Phone: _____

_____

Spouses Name: _____ Date of Birth: _____

Drivers License#: _____

SSN#: _____

Employer: _____ Work Phone: _____

Work Address: _____

_____

**Referred By**

Name: _____ Phone #: _____

**Emergency Contact**

Name: _____ Phone #: _____

Address: _____

**Please give 24 hrs advance notice if unable to keep an appointment.**

**Appointments not cancelled within 24 hrs or missed appointments are billed at the rate of $50.00**

**Signature:** _____ **Date:** _____

400 E US Highway 67 • Duncanville, Texas 75137 • **tel** 214.339.5150 • **fax** 214.339.5151 • www.drdonna4kidsteeth.com

**Financial Policy**

It is our financial policy to collect fees at the time service was provided. For your convenience, we accept cash, check, MasterCard, Visa, American Express, and Discover. If you wish to pay out your balance with monthly payments, we are pleased to offer you three, six, or twelve months interest free through a program called Care Credit. You may request an application at the window, and it is free to apply. If you do not qualify for this program, please be prepared to pay your account in full at the time of checkout. Any unpaid balance is subject to actions by a professional collection agency up to and including legal actions by the State District Attorney's Office.

**Dental Insurance Holders**

As a courtesy to our patients, we will be happy to file claims with your insurance provided that you supply us with accurate and up to date information. Your dental insurance is a contract between the insurance company and you the policy holder; **WE ARE NOT A PART OF THAT AGREEMENT.** Please be aware that state law requires us to collect any deductable, co-pay, or benefits for any reason, **YOU** remain financially responsible for the balance on your account. This is due immediately, and it will be expected that you make arrangements to clear your account accordingly.

Our fees are usually covered up to the maximum paid by your insurance. Some insurers pay claims as a percentage (i.e. 50%, 80%, etc.) of what they regard as the "Usual and Customary" charge for their plans. Our fees are considered appropriate for pediatric dentistry in this area.

**If you have any questions please feel free to contact any member of my staff prior to the start of your child's treatment.**

**Authorization to Treat:**

I authorize Donna J. Barefield, DDS, MSD and/ or her associates to treat the aforementioned patient using restorative and/ or surgery techniques that are reasonable and necessary as the doctor deems advisable, including the use of nitrous oxide (laughing gas). I understand that the treatment plan presented, along with the fee outlined, could change depending upon the time elapsed since the examination and the extent of decay.

Signed _____ Date _____

**Assignment of benefits:**

In consideration of services rendered I hereby transfer and assign to Donna J. Barefield, DDS, MSD and her associates all right title and interest in any payment due me for services provided in the policy and polices of insurance held by me. I further agree and authorize Donna J. Barefield, DDS, MSD to release information requested by the insurance company or its representatives.

Signed _____ Date _____

**Release:**

I understand and agree that I am responsible for all charges pertaining to my medical care, regardless of my insurance status. I have read the Financial Policy above and completed the patient registration form. This information is true and correct to the best of my knowledge. I am responsible for notifying you of any changes.

Signed _____ Date _____

# PATIENT ACQUAINTANCE RECORD

**Please note: This form must be completed by the child's parent/legal guardian.**

Child's name:_____ Sex: ☐M ☐F Age:____
Date of birth:_____ Date of last physical exam:_____
Physician's name:_____
Physician's phone number:_____ and FAX number:_____

**In order for us to provide dental care for your child in a safe and appropriate manner we will need to have a thorough understanding of your child's physical and emotional history and conditions. Please mark the items listed below that your child has had in the past or currently has. Please do not omit any facts. Thank you.**

☐Birth defects or Syndromes
☐Large tonsils
☐Asthma
☐Cystic Fibrosis
☐Breathing problems
☐Sleep Apnea
☐Diabetes
☐Heart Disease/Condition
☐Heart Murmur
☐Abnormal blood pressure
☐Rheumatic Fever
☐Epilepsy
☐Seizures
☐Prolonged bleeding/hemophilia
☐Sickle Cell Disease or Trait
☐Cancer/Tumors/Malignancies
☐HIV positive
☐Cleft Lip or Palate
☐Eczema/Psoriasis
☐Allergy to rubber or latex
☐ADD or ADHD
☐Kidney disease
☐Autism
☐Shunt placement
☐Tuberculosis
☐Emotional/Mental/Developmental condition
☐Hepatitis/Jaundice/Liver disease
☐Artificial joints, valves, plates, or devices
☐Adverse reaction to local anesthetic ('caine' anesthetics)
☐Anemia
☐Cerebral Palsy/Neurologic disorder
☐Thyroid or Endocrine disease
☐Food/Dye/Environmental allergy
☐Speech difficulty
☐Eye or sight disorder
☐Hearing loss or ear problems
☐Mouth injuries
☐Skin infections/Ringworm

**Please list any medicines your child is currently taking:**

_____

**Please list any medicines that have caused an allergic reaction for your child:**

_____

**Please list any surgeries or hospitalizations your child has undergone:**

_____

**Please list any adverse reactions your child has experienced with sedatives:**

_____

**Please list any unfavorable experiences your child has had due to a medical or dental procedure:**

_____

_____

_____ _____ _____
Name of person completing this form (Please **PRINT**) Relation to patient Date

_____ _____
Signature of Parent/Legal Guardian Signature of dentist reviewing history

## CONSENT FOR ABSENT PARENT

Patients Name: _____ Date of Birth: _____

In the event that I cannot be present in the office for my child's dental care, I hereby give the following named relatives permission to bring my child to dental appointments and to make any and all treatment decisions for my child. I attest that the named individuals are 21+ years of age.

1) _____ (relationship to patient)

2) _____ (relationship to patient)

3) _____ (relationship to patient)

I understand treatment of the primary or permanent teeth rendered for my child during my absence can include, but is not limited to examination, x-rays, dental cleaning, fluoride treatment, white plastic fillings, metal crowns, white plastic crowns, nerve treatments/ pulp therapy, extractions, sealants, space maintainers, treatment for dental/ medical emergencies. I further acknowledge and understand that my child will be treated using nitrous oxide/ oxygen analgesia (laughing gas), and may require local anesthesia injection for numbing.

I attest that I am the parent/ legal guardian of the child named at the top of this form, and I give consent for the above named individuals to make any and all treatment decisions for my child in my absence.

_____ _____

Printed Name of Parent/Legal Guardian Relationship to patient

_____ _____

Signature of Parent /Legal Guardian Date

# Electronic Consent-Barefield Pediatric Dentistry

Patient Name: _____ Date of Birth:_____

I agree that Barefield Pediatric Dentistry may communicate with me electronically at the email address below. I also agree to the dental practice communicating electronically with specialists that I may be referred to via email.

**I am aware that there is some level of risk that third parties might be able to read unencrypted emails.**

I am responsible for providing the dental practice any updates to my email address.

I can withdraw my consent to electronic communications by calling or writing to:

214-339-5150 400 E. US Hwy 67, Duncanville, Texas, 75137

Email Address (PLEASE PRINT CLEARLY):

_____ - _____

Patient Signature:_____

Date:_____

# Barefield Pediatric Dentistry

* You May Refuse to Sign This Acknowledgment*

**I have received a copy of this office's Notice of Privacy Practices.**

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)_____

_____

## Receipt of HIPAA Policies and Procedures
## Barefield Pediatric Dentistry

I have received and reviewed a copy of our dental practice's privacy, security and breach notification policies and procedures.

I understand that I should ask our dental practice's Privacy Official if I have any questions about these policies and procedures.

Print Name:_____

Signature:_____

Date:_____

**Submit**