Stroud Pediatric Dentistry

Robert Casey Stroud, D.D.S. – Michael L. Ball, D.D.S.
134 El Chico Trail., Suite 101, Willow Park, TX 76087
Office: 817-441-2425 Fax: 817-441-2491 www.brushflosswin.com

Date _____

Patient's Name _____ **Age** _____ **Date of Birth** _____/_____/_____
☐ **Male** ☐ **Female** **Weight** _____ **Nickname** _____
Your Name _____ **Relationship to Child** _____
Child's Physician _____
Name of school attending _____ **Grade** _____
Do we see other children in the family? ☐ **yes** ☐ **no**
Other children in family (names/ages) _____
Whom may we thank for referring you? _____

HEALTH INFORMATION:

☐ ADD/ADHD	☐ Asthma	☐ Autism	☐ Blood Disorder
☐ Cancer/Tumors	☐ Cleft Lip/Palate	☐ Diabetes	☐ Epilepsy/Seizures
☐ Emotional Issues	☐ Hearing Disorder	☐ Heart Issue/Murmur	☐ Hepatitis
☐ HIV/AIDS	☐ Kidney Disorder	☐ Liver Disorder	☐ Lung Disorder
☐ Mental Disorder	☐ Pregnancy	☐ Rheumatic/Scarlet Fever	☐ Sinus Issues
☐ Speech Issues	☐ Thyroid Disorder	☐ Tuberculosis	☐ Vision Problems

☐ **Other** _____
Please explain any above checked (if necessary):
_____
Is your child allergic to any of the following? ☐ **Latex** ☐ **Red Dye** ☐ **Penicillin**
☐ **Other Antibiotic (list type)** _____ ☐ **Nut (list type)** _____
☐ **Other allergy (specify)** _____
Is your child currently taking any medications? ☐ **yes** ☐ **no**
If yes, please list _____
Has your child ever been hospitalized or had any surgical procedures? ☐ **yes** ☐ **no**
If yes, explain _____
Are immunizations up-to-date? ☐ **yes** ☐ **no**

DENTAL INFORMATION:

Is this your child's first dental visit? ☐ **yes** ☐ **no**
If no - Date last seen _____ **Location** _____
Has your child had an unfavorable dental experience? ☐ **yes** ☐ **no**
If yes, please explain _____
Has your child had or currently have a toothache? ☐ **yes** ☐ **no**
If yes, please explain _____
Has your child ever had an oral habit? ☐ **Thumb/finger sucking** ☐ **Pacifier** ☐ **Other** _____
Does your child ever grind their teeth? ☐ **yes** ☐ **no** **Explain** _____
How do you expect your child to do today? ☐ **Good** ☐ **Fair** ☐ **Poor**
Please let us know of any special concerns or important information that you feel would help us take better care of your child _____
_____

Signature _____ **Date** _____

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PATIENT ACCOUNT INFORMATION

Date _____ **Child(ren)'s Name(s)** _____

_____

Child(ren)'s Address _____

City_____ **State**_____ **Zip** _____

Emergency Contact _____ **Phone #** _____

MOTHER'S INFORMATION: ☐ **Mother** ☐ **Stepmother** ☐ **Legal Guardian**

Name _____ **DOB** _____ **SS#** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Mobile Phone** _____

Employer _____ **Position** _____

Work Phone _____ **Driver's License #** _____

Email _____ **Mother's Dentist** _____

FATHER'S INFORMATION: ☐ **Father** ☐ **Stepfather** ☐ **Legal Guardian**

Name _____ **DOB** _____ **SS#** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Mobile Phone** _____

Employer _____ **Position** _____

Work Phone _____ **Driver's License #** _____

Email _____**Father's Dentist:** _____

Person Responsible for Account: _____

Dental Insurance? ☐ **yes** ☐ **no**

The undersigned hereby authorizes Stroud Pediatric Dentistry to perform the examination and, after explanation, provide necessary dental services using methods deemed appropriate for the care of the above named child(ren). The consent shall remain in force and effect until cancelled by either party.

I understand that I am responsible for the full cost of dental treatment for the above child(ren) regardless of insurance coverage.

I understand that I am responsible for notifying this office of any accidents, major illnesses or change in medical history of the above named child(ren).

Print Name _____ **Date** _____

Signature _____ **Relationship** _____

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FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. **Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards. (VISA, MasterCard and Discover). There will be a $35.00 service charge for all returned checks.**
2. **You may assign insurance payment to our office and we will file the primary insurance for you. Secondary insurance will be filed only if the correct information is provided at the time of service.**
3. **You must provide the office with correct dental insurance information at the time of the service. This includes the mailing address, phone and group number. If insurance coverage cannot be verified, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.**
4. **If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and estimated co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Any remaining balances will be billed to you after a claim is paid. Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the type of plan purchased by your employer and is not related to our professional fees.**
5. **The office cannot carry insurance balances longer than 45 days; if the insurance carrier does not pay a claim, you are responsible for the balance in full. Our office will make every reasonable effort to obtain payment from your insurance company. Any additional insurance appeals will become your responsibility. We will be happy to provide you with any necessary forms or receipts.**
6. **Past due accounts will be notified via statement notes. If the account remains unpaid, we will be required to employ a collection service to collect payment.**
7. **The parent or guardian who brings the child for treatment is the responsible party. This person is required to pay for services rendered regardless of what a divorce decree may state.**

AUTHORIZATION

I authorize Stroud Pediatric Dentistry and staff to release any information concerning my case to my insurance company.

I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

Patient Name(s) (Please Print) _____

Name of Responsible Party (Please Print) _____

Signature of Responsible Party_____ **Date** _____

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INSURANCE INFORMATION

Date _____ **Child(ren)'s Name(s)** _____

In order to file your insurance all information must be provided.

Primary Dental Insurance

Insured's Name _____ **DOB** _____/_____/_____
Insured's Address (if different from child) _____
_____
Relationship to patient _____ **SS#** _____
Employer _____ **Work Phone** _____
Occupation _____ **Employee ID #** _____
Insurance Company _____**Group #** _____
Insurance Company Phone # _____
Insurance Company Address _____
_____

Secondary Dental Insurance

Insured's Name _____ **DOB** _____/_____/_____
Insured's Address (if different from child) _____
_____
Relationship to patient _____ **SS#** _____
Employer _____ **Work Phone** _____
Occupation _____ **Employee ID #** _____
Insurance Company _____**Group #** _____
Insurance Company Phone # _____
Insurance Company Address _____
_____

Assignment of Benefits

In consideration of services rendered, I hereby transfer and assign to: Robert Casey Stroud, DDS, PC 134 El Chico Trl., Ste. 101 Willow Park, Texas 76087 all rights, title and interest in any payment due me services as provided in the policy or policies of insurance held to me. I agree to pay Robert Casey Stroud, DDS, PC the charges which exceed the amount paid by the policies held by me. I further agree and authorize the above named office to release any information requested by the insurance company(s) or its representatives. The undersigned accepts full responsibility for the account.

Policy Holder or Authorized Agent: _____**Date:** _____