Robert Casey Stroud, D.D.S., P.C.

Pediatric and Adolescent Dentistry **Phone: 817-441-2425** **Fax: 817-441-2491**

Date:

_____

Patient Information

Patient's Name _____ Nickname _____

Male ❑ Female ❑ Date of Birth _____/_____/_____ Age _____ Weight_____

Social Security # _____ Phone (Home) _____

Child's Home Address _____
Street Apt. #

_____
City State Zip Code

Child's Physician _____ Phone # _____

With whom does the patient live? _____
Name of school attending _____ Grade _____

Other children in family – names/ages _____

Emergency Contact _____ Phone #_____

Whom may we thank for referring you? ❑ Doctor ❑ Parent ❑ Patient _____
Referral Address: _____

Health Information

Are immunizations up-to-date? ❑ yes ❑ no

Has your child ever had any of the following? Please check all that apply:

❑ ADD/ADHD	❑ Diabetes	❑ Kidney Disorder	❑ Sinus Issues
❑ Allergies (Environmental)	❑ Emotional Issues	❑ Liver Problems	❑ Speech Problems
❑ Anemia	❑ Epilepsy/Seizures	❑ Lung Problems	❑ Thyroid Disorder
❑ Asthma	❑ Hearing Problems	❑ Mental Disorder	❑ Tuberculosis
❑ Blood Disorder	❑ Heart Condition	❑ Mumps/Measles	❑ Vision Problems
❑ Cancer/Tumors	❑ Hepatitis	❑ Pregnancy	❑ Other:_____
❑ Chicken Pox	❑ HIV/AIDS	❑ Rheumatic/Scarlet Fever	

Please explain any above checked (if necessary):

_____

Has your child ever been hospitalized or had any surgical procedures? ❑ yes ❑ no
If yes, explain: _____

Is your child allergic to any of the following?

	Y	N		Y	N
Aspirin	❑	❑	Codeine	❑	❑
Acrylic	❑	❑	Metals	❑	❑
Penicillin	❑	❑	Local Anesthetic	❑	❑
Latex	❑	❑	Other: _____		

Is your child currently taking any medications?
❑ yes ❑ no
If yes, please list: _____

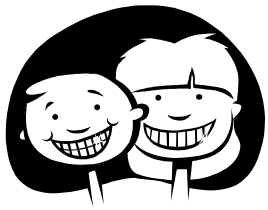
_____

Has your child been seen by another dentist? ❑ yes ❑ no
Date: _____ Location: _____
Has your child had an unfavorable experience? ❑ yes ❑ no
Does your child currently have a toothache? ❑ yes ❑ no
How frequent? _____

Was your child breast-fed? _____ Bottle –fed? _____ Age discontinued: _____
Does your child have a history of: Thumb/finger sucking: _____ Pacifier: _____ Sippy Cup: _____
What is your water source? Public system: _____ Private well: _____ Other: _____
How would you rate your own anxiety at this moment? ❑ High ❑ Medium ❑ Low
How do you expect your child to react in the dental chair? ❑ Good ❑ Medium ❑ Poor

All the information above is correct to the best of my knowledge.

Please sign: _____



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Patient's Name(s) _____

Date:

_____

Parent Information

Mother's Information: ❑ Mother ❑ Stepmother ❑ Legal Guardian
Name: _____ DOB: ____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Position: _____
Social Security # _____TX DL # _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Mother's Dentist: _____

Father's Information: ❑ Father ❑ Stepfather ❑ Legal Guardian
Name: _____ DOB: ____/_____/_____
Address: _____
City: _____ State: _____ Zip: _____
Employer: _____ Position: _____
Social Security # _____TX DL # _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Father's Dentist: _____

Person responsible for account: _____
Do you have insurance? ❑ yes ❑ no

Insurance Information

Primary Dental Insurance: In order to file your insurance all information must be provided.
Insured's Name: _____ DOB: ____/____/_____
Relationship to patient: _____ Soc. Sec. #: _____
Employer: _____ Work Phone: _____
Occupation: _____ Employee ID #: _____
Insurance Company: _____ Ins. Comp. Phone #: _____
Ins. Comp. Address: _____
Group #: _____

Secondary Dental Insurance:
Insured's Name: _____ DOB: ____/____/_____
Relationship to patient: _____ Soc. Sec. #: _____
Employer: _____ Work Phone: _____
Occupation: _____ Employee ID #: _____
Insurance Company: _____ Ins. Comp. Phone #: _____
Ins. Comp. Address: _____
Group #: _____

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 dentist 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: _____

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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 parent is required to pay for services rendered regardless of what a divorce decree may state.**

AUTHORIZATION

I authorize Dr. Robert Casey Stroud 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)

_____ _____

Signature of Parent or Responsible Party Date