**Panther Creek Dental**
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/



# NEW PATIENT FORM (MINOR)

## Basic Information

| | | | |
|---|---|---|---|
| Name: | | Gender: | |
| Preferred Name: | | DOB: | |
| Referral source: | | School: | |
| Referred by: | | Special needs: | |

## Contact Information

| | |
|---|---|
| Mobile phone: | |
| Home phone: | |
| Email: | |
| | |

## Address Information

| | |
|---|---|
| Street address: | |
| City: | |
| State: | |
| ZIP: | |

## Parent/Guardian (Primary Contact)

| | |
|---|---|
| Full Name: | |
| Relation: | |
| DOB: | |
| Mobile phone: | |
| Email: | |
| Has legal custody: | |
| Employer: | |

## Parent/Guardian (Secondary)

| | |
|---|---|
| Full Name: | |
| NOT PROVIDED | |
| | |
| | |
| | |
| | |
| | |

## Parent/Guardian (Primary Contact)

| | |
|---|---|
| Home phone number | |

Patient's signature: Date:

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# CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Panther Creek Dental and their staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary to diagnose and/or treat my childs dental problem. I will allow photographs to be taken of my child or childs teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. We will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Panther Creek Dental of any changes in my childs medical status.

Patient's signature: Date:

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# PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization, or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment, or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

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# FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $100.00. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

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# COMMUNICATION CONSENTS

## EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Panther Creek Dental offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Panther Creek Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, Panther Creek Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Panther Creek Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Panther Creek Dental.

Patient's signature: Date:

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## TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Panther Creek Dental offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Panther Creek Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Panther Creek Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Panther Creek Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Panther Creek Dental.

Patient's signature: Date:

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# HEALTH HISTORY
## | DOB:

### Summary

| | |
|---|---|
| Medical Conditions | **none listed** |
| Allergies | **none listed** |
| Medications | **none listed** |

### Healthcare Provider

| | |
|---|---|
| Child's Physician/Pediatrician | |
| Physician/Pediatrician phone number | |
| Pediatrician's Address | |
| Preferred Pharmacy | |
| Date of last physical exam | |

### General Health Information

| | |
|---|---|
| Does your child have any allergies? | |
| Is your child currently taking any medications? | |
| Has your child ever been hospitalized, had general anesthesia, or emergency room visits? | |

### Medical Conditions

| | |
|---|---|
| Is your child past due for any vaccinations? | |
| Have you ever been told that your child needs to take antibiotics before dental treatment? | |
| Were there any difficulties at birth? | |
| Is your child currently being treated for, or has a history of any medical conditions? | |

Patient's signature: Date:

Doctor's signature: Date:

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# DENTAL HISTORY
## | DOB:

### General Information

| | |
|---|---|
| Who was your child's previous Dentist? | |
| Date of your child's last dental exam | |
| Date of your child's last cleaning | |
| What is the reason for your child's dental visit? | |

### Personal History

| | |
|---|---|
| Has your child experienced any unfavorable reaction from previous dental care? | |
| Does your child suck a finger, thumb, or pacifier? | |
| Does your child have pain with chewing, yawning, or wide opening? | |
| Does your child go to bed with a bottle or sippy cup? | |
| Does your child snack frequently? | |
| Has your child had local anesthetic? | |
| Has your child been sedated for dental treatment? | |
| Have your child's teeth ever been injured? | |
| Does your child use fluoride toothpaste? | |

### Dental Problems

| **Please check if your child is having problems with any of the following** | |
|---|---|
| Cavities | |
| Trauma | |
| Orthodontics | |
| Toothache | |
| Gum Infections | |
| Jaw Sounds | |
| Sensitive Teeth | |
| Color of Teeth | |
| Grinding of Teeth | |
| Mouth Breathing | |
| Other | |

Patient's signature: Date:

Doctor's signature: Date:

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# DENTAL INSURANCE INFORMATION
## | DOB:

Created at: **06/18/2022 8:51:21 AM**

### Primary Insurance Information

| | |
|---|---|
| Do you have a dental insurance? | |
| Would you like to upload insurance card photo? | |
| Patient’s relationship to the Insurance Holder | |
| Policy Holder’s Name | |
| Policy Holder’s Date of Birth | |
| Policy Holder’s SSN | |
| Policy Holder’s Address | |
| Policy Holder’s City | |
| Policy Holder’s State | |
| Policy Holder’s ZIP | |
| Policy Holder’s Phone Number | |
| Policy Holder’s Employer | |
| Dental Insurance Company | |
| ID Number | |
| Group Number | |
| Phone number on the back of your insurance card | |
| Address on the back of your insurance card | |

### Secondary Insurance Information

| | |
|---|---|
| Do you have a secondary dental insurance? | |
| That's all! If you would like to add secondary insurance, you need to provide primary insurance first. | |
| Would you like to upload insurance card photo? | |
| Patient’s relationship to the Insurance Holder | |
| Policy Holder’s Name | |
| Policy Holder’s Date of Birth | |
| Policy Holder’s SSN | |
| Policy Holder’s Address | |
| Policy Holder’s City | |
| Policy Holder’s State | |
| Policy Holder’s ZIP | |
| Policy Holder’s Phone Number | |
| Policy Holder’s Employer | |
| Dental Insurance Company | |
| ID Number | |
| Group Number | |

| | |
|---|---|
| Phone number on the back of your insurance card | |
| Address on the back of your insurance card | |

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# COVID-19 QUESTIONNAIRE
## | DOB:

### COVID 19 QUESTIONNAIRE

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID19, or whether you have experienced any signs or symptoms associated with the COVID19 virus.

| | |
|---|---|
| Have you, your child or anyone in your household had a fever or above normal temperature? | |
| Have you, your child or anyone in your household experienced shortness of breath or had trouble breathing? | |
| Have you, your child or anyone in your household had a dry cough? | |
| Have you, your child or anyone in your household had a runny nose? | |
| Have you, your child or anyone in your household recently lost or had a reduction in your sense of smell? | |
| Have you, your child or anyone in your household had a sore throat? | |
| Have you, your child or anyone in your household been in contact with someone who has tested positive for COVID?19? | |
| Have you, your child or anyone in your household tested positive for COVID?19? | |
| Have you, your child or anyone in your household been tested for COVID?19 and are awaiting results? | |
| Have you, your child or anyone in your household traveled outside the United States by air or cruise ship in the past 14 days? | |
| Have you, your child or anyone in your household traveled within the United States by air, bus or train within the past 14 days? | |

### I CONSENT THAT THE INFORMATION ABOVE IS CORRECT

I fully understand and acknowledge the above information, risks, and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate

Patient's signature: Date:

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# GUARDIAN AUTHORIZATION FORM
## | DOB:

I authorize the person listed below to accompany my child, to his/her dental appointment.

| | |
|---|---|
| Authorized Person's Name | |
| Authorized Person's Relation | |
| I agree to the following treatment to be performed in my absence | |
| Examination | |
| Radiographs (x-rays) deemed necessary | |
| Cleaning | |
| Fluoride | |
| Silver diamine fluoride | |
| Necessary restoration of decayed teeth | |
| Nitrous oxide (laughing gas) | |
| Extractions | |
| Emergency treatment as necessary | |

### GUARDIAN AUTHORIZATION CONSENT

I request that I be contacted at the phone number below if treatment needs or recommendations change during treatment. If treatment recommendations change during treatment and I am not able to be reached I authorize the person accompanying my child to make an informed decision and authorize Panther Creek Dental to perform the necessary and recommended treatment. I understand this guardian authorization will remain in effect until revoked in writing.

Legal guardian's/Parent's signature:

Date:

| | |
|---|---|
| Contact number | |