



S.M. HAIDER, D.D.S., P.A.

Pediatric Dentistry • Facial Orthopedics • Orthodontics

PATIENT ACQUAINTANCE INFORMATION

Child's Name _____ Age _____ Date of Birth _____

Prefers to be called _____ Sex _____ Weight _____

I. CHILD'S MEDICAL HISTORY

- | | Yes | No | |
|--|------------------------------------|---|--|
| 1. Does child have a health problem? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. Is child under care of physician now? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. Is there any history or excessive bleeding in child or family? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4. Has child ever had any emotional, mental, or nervous problem? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5. Has child experienced any unfavorable reactions to any drugs? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6. Regular medications being taken by child _____ | | | |
| 7. Medicines or drugs to which child is allergic _____ | | | |
| 8. Any other allergies _____ | | | |
| 9. Previous hospitalizations _____ | | | |
| 10. Has child had any history or difficulty with the following? If so, please check (). | | | |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Cleft lip or Palate |
| <input type="checkbox"/> Lungs | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Cerebral Palsy |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Fainting | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Speech Problems |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Chronic Sinusitis |
| <input type="checkbox"/> Hearing | <input type="checkbox"/> Measles | <input type="checkbox"/> Malignancy | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Handicap/Disabilities | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Allergies to Latex |

DOCTORS NOTES:

II. CHILD'S DENTAL HISTORY

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Has child ever had a local anesthetic? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has child had any unfavorable dental experiences? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Had child had any injuries to the mouth or teeth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does child have a toothache now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has child recently had a toothache? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does child have any mouth habits? (thumbsucking, nailbiting, mouthbreathing) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does child have TMJ problems? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does child have a bite problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Last dental examination _____ | | |
| 10. Last dental X-rays _____ | | |
| 11. Last topical fluoride treatment _____ | | |
| 12. Reason for this visit _____ | | |

Please identify any dental or medical problem of special concern or provide any other information which you think might be important in the care of your child. _____



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III. GENERAL INFORMATION

1. Child's Name _____
2. Parent's Names:
Father _____ Mother _____
3. Home Address _____ Home Phone _____
City _____ State _____ Zip _____
E-mail _____ Cell Phone _____
4. Occupation and place of employment
Father _____ Bus Phone _____
Mother _____ Bus Phone _____
5. Parent or guardian responsible for this account
Name _____
6. Dental Insurance Carrier (if applicable) _____
Policy No. _____ S.S. # _____
7. What other children in your family have we seen? _____
8. Parent's Dentist _____
9. Child's Pediatrician (physician) _____
10. Who referred your child to our office? _____

IV. CONSENT FOR TREATMENT OF A MINOR:

The undersigned hereby authorizes Dr. Haider to perform the examination including x-rays and, after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until cancelled by either party.

Signed _____

Relationship _____ Date _____

All fees for services rendered are payable at the conclusion of each appointment unless other financial arrangement have been made. All account in excess of five weeks past due are subject to a late charge.

INSURANCE CLAIM POLICY

As a courtesy to our patients, we will be happy to file your insurance for you. In order for us to give you the most efficient service possible, you will need to provide our office with all of your current insurance information. In the event that you do not have all of the below information with you, please feel free to use our courtesy phone in the check out area.

Unfortunately, due to the high volume of patients whom have insurance coverage, we must rely on the parents/ guardians to provide this for us. Please fill out the below information, and provides us with your insurance card so that we may make a copy of it for the patient's files.

Patient(s) Name(s): _____

Employee Name: _____

Employee Birth dates: _____

Employee Social Security: _____

Employer: _____

Insurance: _____

Insurance Address: _____

Insurance Group # _____

Insurance Phone # _____

- You will be expected to pay your deductible and estimated insurance % the day of services are rendered, unless other arrangements have been made in advance. Since we file only as a courtesy for our patients, our billing service will send you a statement every month updating you on any insurance payments that have been made toward your account. After 90 days, the balance on the account becomes your (the parents) responsibility, regardless of any pending situations with your insurance. However, if you should ever need our office to re file a claim or assist you with insurance problems, please give us a call.*
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I have read and understand the above insurance policy.

Sign XX: _____ **Date:** _____

Kidz & Teen Dental

Syed M. Haider D.D.S., P.A.
4100 Fairway Court, Bldg #5, Ste 520,
Carrollton, TX 75010
972-939-KIDZ (5439)

Cancellation Policy

We reserve time in our schedule especially for you and your child, and in consideration of others we request at least 24 hours notice prior to cancellation of appointments. We do understand that there are circumstances that may prevent you from keeping your child's appointment, however with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and canceling with less than 24 hours notice does not allow us enough time to schedule another patient in need of treatment, therefore a **cancellation** or **no-show** fee of \$25.00 may apply if your child is unable to make their appointment. Patients that are running late are asked to call as soon as possible to check with the staff if they will still be able to keep their appointment. Also, cancellations are not accepted if left on the answering service and the appointment will not be considered cancelled unless you call during regular business hours and speak with one of our scheduling coordinators.

Patients who have appointments for restorative treatment may have their appointments rescheduled if they are more than 15 minutes late for their appointment time in consideration for other patients.

Appointments cancelled with less than 24 hours notice on a school holiday or an after school time will not be rescheduled on another school holiday or after school appointment time, as they are most popular appointments.

We greatly appreciate your cooperation in helping us providing you with excellent care for your family. Please sign below that you have read, and acknowledge the above information provided to you. You may also have a copy for your records at your request.

Parent/ Guardian:

Date:
