Today's Date: _____ Please use **BLACK** Ink

Pediatrix Dental, PA
6120 S. Staples Street
Corpus Christi, Texas 78413

Patient Name: _____SS#_____D.O.B:_____Male/Female

Address: _____

City: _____State: _____Zip Code:_____

Mother's Name: _____

Home Phone: _____ Work Phone: ____ _____ Cell: ____ _____ Email: _____

Address: _____

SS#:_____ D.O.B.:_____

Employer: _____Address: _____

Name of Insurance: _____

Address: _____

Father's Name: _____

Home Phone: _____ Work Phone: ____ _____ Cell: ____ _____ Email: _____

Address: _____

SS# _____ D.O.B.:_____

Employer: _____ Address: _____

Name of Insurance: _____

Address: _____

Primary/ Secondary Responsible Party Insurance

Name & Address_____

Signature: _____

Child's Pediatrician's Name: _____ Physician Phone_____

Pharmacy Name _____ Pharmacy # _____

You **MUST** confirm by 1:00 p.m. the day before or your appointment **WILL be CANCELLED**. (Please be on time to all appointments)

Parent Signature_____ Date: _____

Today's Date: _____ Please use **BLACK** Ink

Medical Condition Please Circle Yes or No

Y / N ADD, ADHD or Hyperactivity
Y / N Alcohol Abuse
Y / N Anemia
Y / N Heart Murmur (Innocent/Pathological)
Y / N Hemophilia/Bleeding Disorder
Y / N Blood Pressure Disorder
Y / N Blood Transfusion
Y / N Learning Disability
Y / N Cleft Lip/ Palate
Y / N Measles, Mumps or Chicken Pox
Y / N Congenital Birth Defects/ Syndrome
Y / N Pneumonia
Y / N Rheumatic Fever
Y / N Thyroid Problems
Y / N Tetralogy Of Fallot
Y / N Shingles
Y / N Stomach/GI Disorder
Y / N HIV+ AIDS
Y / N Handicaps or Disabilities
Y / N Heart Condition
Y / N Any Stays in Hospital
Y / N Asthma/ Lung Problems
Y / N Implanted Shunts, Pins, Screws
Y / N Kidney Disease/ Transplant
Y / N Cancer, Leukemia, or Lymphoma
Y / N Congenital Birth Defects/ Syndrome
Y / N Psychiatric Problems
Y / N Physical /Emotional Abuse
Y / N Drug/Alcohol
Y / N Ear Infection(s) Otitis Media
Y / N Eye Problem
Y / N Fainting Spells
Y / N Fever Blisters
Y / N Tonsillectomy &/ Or Adenoidectomy
Y / N Use Of Tobacco Products
Y / N Allergy To Sulfa Drugs
Y / N Bruise Easily
Y / N Glaucoma
Y / N Hepatitis or Jaundice
Y / N Diabetes
Y / N Hearing Impairment
Y / N Liver Disease
Y / N Pregnant
Y / N Delayed Development
Y / N Sickle Cell Disease
Y / N Seasonal Allergies/ Hay Fever
Y / N Seizures, Epilepsy Or Convulsions
Y / N Sexually Transmitted Disease
Y /N Penicillin Allergy

Any Allergies: _____ **Medications Taken**_____

**********Medical/ Dental Release Statement: **********

I give my consent for Edith Rojas, D.D.S., Pediatrix Dental, PA to do a complete and thorough examination on the patient previously named, including diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Edith Rojas, D.D.S., Pediatrix Dental of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Dr. Rojas and her staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

_____**Initial**

Requirement for filing insurance Claims To Precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency & understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 30 days of treatment. I hereby authorize payment of insurance benefits directly to Edith Rojas, D.D.S., Pediatrix Dental, PA for performed treatment on my child. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

_____**Initial**

Signature: _____ **(Parent or Guardian)**

Patient Name:_____ **Date of Birth**_____

Today's Date: _____ Please use **BLACK** Ink

Medical Release Authorization (HIPPA)

Parent/ Guardian Name: _____ (if Minor) Date: _____

Patient: _____ Patient SS#_____-_____-_____

I authorize Edith Rojas, D.D.S, to communicate with outside physicians and their staffs, other dentist and their staffs, pharmacists and their staffs, insurance companies and any other health care professional, concerning my medical/dental health care and my billing/ account records held by:

Edith Rojas, D.D.S.
Pediatrix Dental, PA
6120 S. Staples St.
Corpus Christi, Texas 78413
Phone: 361-299-5950
Fax: 361-356-6287 Email info@pediatrixdental.com

I further authorize the electronic, digital, or verbal communication of records or information between Edith Rojas, D.D.S., Pediatrix Dental, PA., and any insurance company, physician's office, dental office, pharmacy, or any other healthcare agencies associated with the dental treatment. All treatments, accidents, and illnesses are covered by this release. I agree to hold harmless the staff and Officers of Edith Rojas, D.D.S.,Pediatrix Dental, PA concerning the release of any dental /medical record(s).

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke consent is not affected.

Patient Signature _____Date :_____(Adult)

Parent/ Guardian Signature: _____Date :_____(If a Minor)

Today's Date: _____ Please use **BLACK** Ink

PEDIATRIX DENTAL, D.D.S., P.A.

FINANCIAL AGREEMENT

Most insurance companies will not cover 100% percent of all dental treatments. Your portion, not covered by insurance, is due at the time the treatment is performed.

A quote of benefits from your insurer is not a guarantee of payment. Frequently insurance companies quote inaccurate benefits –and then decline to pay for certain procedures. We will verify and file insurance claims- but you are ultimately responsible for any unpaid balance on your account. All incurred charges are ultimately the responsibility of the patient regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Our office may not be a party to a contract or any possible restrictions.

We accept cash, personal checks, and credit cards: Visa, MasterCard, and Discover. There will be a 6% service fee for any refunds on credit card transactions.

Payment in full is due when services are performed unless other financial arrangements have been made. If a check is returned for any reason, the office will charge a $35.00 returned check fee and may also suspend your check writing privileges.

Patient will be provided with treatment plans for their dental services. The patient agrees to assign all payments for dental service rendered to Edith Rojas, D.D.S, P.A./Pediatrix Dental.

If an account becomes past due, the office will take all necessary steps to collect the debt. If we have to refer your account to a collection agency or credit reporting bureau, the responsible party agrees to pay all of the collection fees that are incurred.

If we have to refer collection of an account to an attorney or local Justice of the Peace, the patient agrees to pay all lawyer's fees and court costs. In case of a suit, the patient agrees the venue shall be in Corpus Christi, Nueces County, Texas.

Patient who request a copy of their dental records or ask that a copy of their dental records be forwarded to another office are responsible for paying charges for duplication. These costs are specified by the Texas State Board of Dental Examiners and cannot be waived.

By the signing this document, I agree to comply with all of the policies and procedures stated above. This agreement has no expiration date.

Patient Name _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____