PATIENT INFORMATION Date: __________________

Childs Name: ____________________________ Nickname: _________________Gender: ☐M ☐F Birth Date: _____/_____/______

Person filling out paperwork: ________________________ Relationship to child: _________________________________

To receive your child's appointment reminders via Email, please provide your email address:

____

Child's Home Address: ____

City: ____State:________________Zip:_______________________

Parent's marital status: ☐Single ☐Married ☐ Divorced ☐Separated ☐Remarried

FINANCIALLY RESPONSIBLE PARENT/GUARDIAN

Name: ____Relationship to child: ________________________

Birth Date: ________/________/_________ Social Security: _____________-______________-_______________

Address: (if different from above) ____

City: ____State:__________________Zip:______________________

Phone: (Home) _________________________ (Work)____________________________ (Cell)_____________________________

E-mail address: ____

Signature of financially responsible parent/guardian: ____________________________________Relationship: __________________

INSURANCE INFORMATION

Name of Insured: ____ Insured's Relation to Patient: _________________

Address: ____City_________________State____________Zip____________

Insured's Social Security: ____ Birth Date: ________/________/________

Insured's Employer: ___________________________Insurance Company: ___________________ Group Number: ______________

Insurance Identification Number: ________________________________ Insurance Phone Number______________________

As a courtesy, we will file all dental claims within our office. All fees quoted will expire within 90 days and are subject to change. All quotes given are only estimates. Insurance companies do not guarantee payment and we will not know exact amounts due until your insurance company responds to the claim. **REGARDLESS OF WHAT YOUR INSURANCE PAYS, YOU ARE FULLY RESPONSIBLE FOR ANY BALANCES DUE.** Once a payment is received an account statement will be sent. I authorize my insurance company to make payments directly to Cross Timbers Dental on my behalf for treatment rendered. I fully understand that quoted costs are estimates only, and the patient portion may change if treatment changes or the insurance pays more or less than estimated.

Signature of Parent or Guardian____ Date: ____________________

Please sign or initial the following sections below

CONSENT FOR SERVICE AND FINANCIAL AGREEMENT

Thank you for selecting our office for your child's dental care. We are committed to the success of your child's treatment. Please understand that payment at the time of your child's treatment is considered a part of your commitment to our office. We ask that you read and sign this agreement prior to any treatment. **PAYMENT IS REQUIRED AT THE TIME OF TREATMENT.** We accept cash, checks, debit cards and all major credit cards. For extensive treatment, we offer payment plans using third party financing with prior credit approval.

Initial: _______________

MISSED APPOINTMENTS

We will contact you with several reminders of your child's appointment time by mail, email and/or text messages. If you need to change or cancel your appointment, please notify us **48 hours** in advance so we are able to accommodate other patients.

Initial: _______________

PATIENT CONSENT TO THE USE OF HEALTH INFORMATION

Cross Timbers Dental originates and maintains paper and/or electronic records describing your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as a basis for planning your care and communication with other relevant health care providers. It is also a means by which a third-party can verify that conditions were present and services were provided competently.
You have the following rights and privileges:

- To review A *Notice of Information Practices & HIPAA* this is a more detailed description of the use and disclosure of health information prior to signing this consent.
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.
- To revoke this consent in writing, except to the extent that the organization has already taken action.

Cross Timbers Dental has the following rights:

- To refuse treatment if the restrictions prevent Cross Timbers Dental from providing adequate care and are not required to agree to the restrictions requested.
- To change notices and practices. Should Cross Timbers Dental change their notice, they will send a copy of any revised notice to the address I've provided whether U.S. mail or, if I agree, email.

I consent to Cross Timbers Dental:

- To disclose necessary Information by any means including fax, email, telephone, voice, or correspondence to another entity for treatment and/or third party payment.
- Telephone voice mail, answering machines or e-mail for the purpose of leaving an appointment reminder or a message to include name and phone number to call.
- To communicate treatment plans and financial information verbally, by e-mail or in writing with my immediate family.

By signing below, I acknowledge responsibility and agree to the terms. I also consent to the Use of Health Information and have been offered a copy of the HIPAA rights and privileges.

The undersigned agrees to be responsible for any bill incurred on this child for dental treatment should the named responsible party should fail or insurance benefit be denied.

______________________________	____________________	______________________________
Parent or Guardian	Date	Relationship to Patient

*please provide photo ID when handing in paperwork