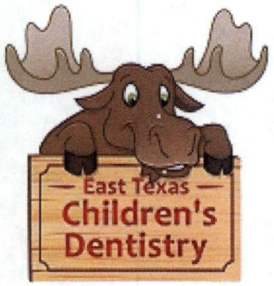


Kenny C. Thompson, D.D.S.
Rebecca B. Ball, D.D.S.
401 W 19th Street
Mount Pleasant, TX 75455
903-577-9900
etcd203@yahoo.com

NAME _____ **SEX: MALE / FEMALE**
Last First Middle Initial

BIRTHDAY ____ / ____ / ____ **AGE** _____ **WEIGHT** ____ **SOCIAL SECURITY NUMBER** _____ / _____ / _____

Have we seen another child in your family? _____ **If yes, who?** _____

What is your child's favorite (pet, sport, toy)? _____ **Who referred you to our office?** _____

Who is your family dentist? _____

Child currently lives with: **Mother** **Father** **Both** **Grandmother** **Grandfather** **Other** _____

YOUR CHILD'S MEDICAL / DENTAL HISTORY

Does your child have any dental problems that you are aware of?
If yes, explain: _____

Please rate your child's medical health: ☐ Good ☐ Fair ☐ Poor

HAS YOUR CHILD:

☐ Yes ☐ No **Ever visited the dentist before?**
When? _____ **Were x-rays taken?** _____

☐ Yes ☐ No **Ever had an unfavorable dental/medical visit? If yes, please explain:**
_____

☐ Yes ☐ No **Exhibited any undesirable mouth habits? If yes, please explain:**
_____

☐ Yes ☐ No **Exhibited TMJ / TMD or tooth grinding problems?**

IS YOUR CHILD:

☐ Yes ☐ No **Currently under the care of a physician / specialist?**

Child's Physician: _____ **Phone #** _____

Child's Specialist: _____ **Phone #** _____

☐ Yes ☐ No **Currently taking ANY prescription / non-prescription medication(s) or dietary / herbal supplement(s)? If yes, please list:**
_____

☐ Yes ☐ No **ALLERGIC TO ANY MEDICATIONS or FOOD PRODUCTS? Please list:**
_____

☐ Yes ☐ No **ALLERGIC to LATEX products?**

☐ Yes ☐ No **Currently taking any birth control?**

☐ Yes ☐ No **Does your child require antibiotic coverage prior to dental treatment due to heart murmur/shunt, etc.?**

PLEASE LIST ALL PERSONS THAT YOU GIVE PERMISSION TO MAKE DECISIONS REGARDING YOUR CHILD'S DENTAL TREATMENT:
(anyone that may bring the child for treatment other than yourself)

_____ _____

PLEASE CIRCLE "YES" or "NO" AS IT RELATES TO YOUR CHILD'S HEALTH

YES	NO	Heart Murmur
YES	NO	Heart problems of any kind
YES	NO	Shunts
YES	NO	Cancer
YES	NO	Diabetes
YES	NO	Rheumatic Fever
YES	NO	HIV positive / AIDS
YES	NO	Hemophilia
YES	NO	Bleeding problems of any kind
YES	NO	Hearing Impairment
YES	NO	Hyperactive
YES	NO	Frequent Headaches
YES	NO	Asthma Last Attack _____
YES	NO	Convulsions/Epilepsy/ Seizures
YES	NO	Pregnancy
YES	NO	Physical/Mental Impairment
YES	NO	Learning Disability
YES	NO	Autism
YES	NO	Dermatologic or Skin conditions
YES	NO	Any hospital stays/operations Please list: _____

Are there any other medical conditions or problems relating to your child? YES NO
If yes, please list: _____
_____

PARENT OR GUARDIAN INFORMATION

FATHER **Name**_____
Last First Middle

Address_____
(where you receive mail) Street or 911 City State Zip

SS#____/____/____ **BIRTHDATE**___/___/_____ **DRIVER'S LICENSE#**_____

TELEPHONE: **HOME**_____ **WORK**_____

CELL_____

E-MAIL ADDRESS_____

PLACE OF EMPLOYMENT_____ **OCCUPATION**_____

DENTAL INSURANCE COMPANY_____

MOTHER **Name**_____
Last First Middle

Address_____
(where you receive mail) Street or 911 City State Zip

SS#____/____/____ **BIRTHDATE**___/___/_____ **DRIVER'S LICENSE#**_____

TELEPHONE: **HOME**_____ **WORK**_____

CELL_____

E-MAIL ADDRESS_____

PLACE OF EMPLOYMENT_____ **OCCUPATION**_____

DENTAL INSURANCE COMPANY_____

In the event of an emergency, whom (other than those listed above) should we contact?
NAME_____ RELATIONSHIP TO CHILD_____
TELEPHONE #_____

PAYMENT OF PROFESSIONAL FEES

- **I understand that payment is due at the time of service.**
- **Any amount estimated NOT to be covered by insurance will be due at the time of service.**

How may we expect your payment? **(Please check one)**

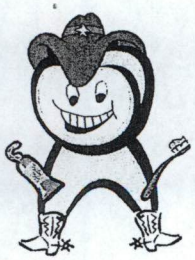
☐ **Cash or check** ☐ **Credit Card** ☐ **Insurance** ☐ **Medicaid**

- The information I have given is correct to the best of my knowledge that it will be held in the strictest of confidence. I also understand that it is my responsibility to inform this office of any changes in my child's medical status, address, or any other personal information. I authorize the dental staff to perform any dental services that they may deem necessary.

- I give permission to East Texas Children's Dentistry, P. A., to use my child's first name and picture on their website or for any advertis announcements and/or educational use.

- By signing this form, I agree to take full financial responsibility for this child's account. I understand that my estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is payable by me.

- I hereby authorize payment of dental insurance benefits, if any, to be made directly to East Texas Children's Dentistry, P.A.



East Texas Children's Dentistry, P.A.

Kenny C. Thompson, DDS
401 W 20th Street
Mt. Pleasant, TX 75455
(903) 577-9900

OFFICE AND FINANCIAL POLICY

Our office is committed to providing your child with the best dental care possible. We welcome your child to our practice and in doing so we would like to take a few moments to advise you of our office policies.

We welcome parents/legal guardians back for initial and emergency visits. However, we ask that parents and other visitors remain in the waiting area during routine check-ups and operative visits. Operative visits include fillings, stainless steel crowns, extractions, etc. Dr. Thompson has found through his experience of treating children that often time children respond more positively when parents remain in the waiting area. A member of our staff will let you know if there is a need for an exception to this office policy. **We treat children up to age 18 yrs or graduation from high school, whichever falls first**. When the patient turns 18, we refer them to a general dentist for all their dental care.

Please call in advance if you are unable to keep your scheduled appointment. **AFTER THREE MISSED APPOINTMENTS, WE WILL NO LONGER PROVIDE DENTAL SERVICES FOR YOUR CHILD**. Should this situation arise, we will forward your dental records to the new provider's office.

If you have dental insurance, we will be happy to assist you with filing your dental claims. To do so, we require your assistance and your understanding of our financial policy. **PAYMENT FOR SERVICES IS DUE AT THE TIME THAT SERVICES ARE RENDERED!!** We accept cash, checks (with proper identification), MasterCard, Visa, and CareCredit. Our office uses a check verification company called CrossCheck. When you pay by check, you are authorizing our office to process that check either by traditional deposit, by converting the check to an electronic transaction, or by a pre-authorized draft. If your check is declined for any reason, CrossCheck will assume the responsibility for processing your check by other means if necessary. We will file your insurance as a COURTESY. Our new patient form must be filled out completely for our office to file claims for you. Any balance older than 30 days is subject to be turned over to collections unless other arrangements have been made in advance. PLEASE UNDERSTAND:

1) **Your Insurance is a contract between you, your employer, and the Insurance company.** We are not a party to that contract.
2) **UCR is defined as usual, customary, and reasonable**. However, any amount unpaid by your insurance company is **YOUR** responsibility. **WE ARE NOT IN NETWORK WITH ANY INSURANCE COMPANIES, SO YOU WILL BE BALANCE BILLED FOR ANY AMOUNT NOT COVERED BY YOUR PLAN.**
3) **Not all services are a covered benefit in all contracts.** Some insurance companies select certain services that they refuse to cover.
4) **DIVORCE DECREES ARE BETWEEN YOU AND YOUR EX-SPOUSE.** Our office does not attempt to resolve these types of disputes. The parent that signs our paperwork is the person that we will hold responsible for any balance on the account.

We must emphasize that our relationship as your dental provider is with you and your child, NOT your dental insurance company. Filing insurance is a courtesy that we extend but ultimately all fees are your responsibility from the date the service is rendered. If problems should arise that affect your ability to make prompt payment, please advise our office immediately for assistance. Please don't hesitate to ask if you have any questions regarding the above information. We are here to help you!!!!!!!!!!

Date: _____ Signature: _____

CONSENT FOR DENTAL TREATMENT

TO THE PARENT: You have the right as a parent, to be informed about your child's condition and the recommendation surgical, medical, or diagnostic procedure to be used so that you make the decision whether or not to undergo the procedure after knowing the risks and hazards involved. This disclosure is not meant to scare or alarm you; it is simply an effort to make you better informed so that you may give or withhold your consent to the procedure.

With regard to my child, _____ I, _____
(Patient's Name) (Parent or Legal Guardian)
voluntarily request Dr. Kenneth C. Thompson and the dental staff of East Texas Children's Dentistry, P.A., to treat my child's condition, which has been explained to me.

I understand and consent to treatment planned for my child which may include:

- Cleaning of the teeth and the application of topical fluoride
- Application of plastic "sealants" to the grooves of teeth
- Treatment of diseased or injured teeth with dental restorations (including silver and tooth colored fillings, stainless steel crowns, and nerve treatment)
- Removal (extraction) of one or more primary and/or permanent teeth
- Replacement of missing teeth with dental prosthesis
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
- Any other procedure, including but not limited to x-rays and use of local anesthetics deemed necessary or advisable to the planned treatment

I understand that all efforts will be made to obtain the cooperation of my child by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. I further understand and consent to the use of behavior management techniques to eliminate disruptive behavior or prevent my child from causing injury to themselves or the staff due to uncontrollable movements in order to facilitate the rendering of necessary dental treatment including but not limited to various forms of physical restraint and nitrous oxide with oxygen (laughing gas). If I wish any exception(s) I have so noted as follows: (if you wish no exception, please write "NONE") _____.

Alternate forms of treatment, as well as the option of no treatment, have been explained to me with the advantages, disadvantages, and risks of each. I have been advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied as to the result or as to cure.

Although their occurrence is extremely rare, some risks are known to be associated with the proposed sedative drugs including but not limited to: nausea, vomiting, allergic reaction, breathing problems, brain damage, stroke, heart attack, and paralysis, the loss of function of any organ or limb, or disfiguring scars associated with such procedure or procedures. I further understand and accept that though unlikely, complications may require hospitalization and may even result in death.

- **I hereby state that I have read and understand this consent, that I have been given an opportunity to ask any questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner.**
- **I further understand that this consent will remain in effect until such time that I terminate in writing.**
- **I understand that although my consent has been given to the above treatment, I will be informed of specific treatment needed prior to treatment being performed.**

Signature of Parent or Legal Guardian _____

Signature of Witness _____ Date _____

I certify that the above procedures have been explained to the parent or guardian.

_____
Kenneth C. Thompson, DDS

East Texas Children's Dentistry, P.A.
Kenny C. Thompson, DDS
401 W. 19th Street
Mt. Pleasant, TX 75455
(903) 577-9900

NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW MEDICAL OR DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY.

During the course of serving you interests it may be necessary to share information with other Health Care Providers. The following are some of those instances:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- For payment purposes, we may use the services of a billing or collection agency.
- A second opinion by another Health Care Provider may be deemed necessary.

We here at East Texas Children's Dentistry, P.A. are committed to obeying all Federal, State, and local law and regulations regarding the Health Insurance and Portability Act (HIPAA). We will obtain written authorization from the parent or legal guardian if any uses or disclosures other than the ones listed above are needed. This authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comments regarding HIPAA or your protected health information, feel free to contact our Compliance Office, Delann Thompson, at 903-577-9900.

*I have read and understand the above notice of Privacy Practices.

Date: _____ Signature: _____