Welcome!

Drs. Steve and Angie Hernandez
Dr. Regina Jensen
Dr. Keith Rice
Dr. Jodi Mason

Health History Form

Child's Information:

Child's Name _____
Last First MI
Nickname _____ ○ Male ○ Female

Siblings we treat _____

Date of Birth _____/_____/_____

Child's Age _____

Home Phone _(_____)_____-_____

SS# _____-_____-_____

Home Address _____

_____
City State Zip

Mother's Information:

Mother's Name_____
Last First MI
Mother Step Mother Guardian
Date of Birth ___/___/___ SS# _____-_____-_____

Employer _____

Work # _(_____)_____-_____ EXT _____

Cell # _(_____)____-_____

Father's Information:

Father's Name _____
Last First MI
Father Step Father Guardian
Date of Birth ___/___/____ SS# _____-_____-_____

Employer _____

Work # _(_____)_____-_____ EXT _____

Cell # __(_____)_____-_____

Who is accompanying the child today?

Name _____

Relationship _____

Do you have legal custody of this child?
○ No ○ Yes

Account and Insurance Information:

Person Responsible for Account:

Name _____
Last First MI

Relationship _____

Billing Address _____

_____
City State Zip

Home # _(___)_____-_____

Work # _(___)_____-_____

Cell # _(___)_____-_____

E-mail _____

Primary Dental Insurance:

Insurance Co. Name _____

Insurance Co. Address _____

_____
City State Zip

Insurance Co. Phone # __(___)____-_____

Group # _____

ID # _____

Policy Holder's Name _____

Policy Holder's Employer _____

Dental History:

Is this your child's first visit to the dentist? _____
If not, how long since their last dental visit? _____

Were any x-rays taken at previous visit? _____

Have there been any injuries to the teeth, face or mouth?
_____

If yes, please explain _____

_____

_____

Reason for today's dental visit _____

_____

Does your child have any of the following habits?

Y N Lip Sucking / Biting

Y N Nail Biting

Y N Nursing / Bottle Feeding

Y N Thumb / Finger Sucking

Has your child ever had a serious or difficult problem associated with previous dental work?

_____

If yes, please explain_____

_____

Is the child's water fluoridated? _____

Is the child taking fluoride supplements? _____

Has the child ever had any pain or tenderness in

his/her jaw/joint? (TMJ/TMD)? _____

Does the child brush his/her teeth daily? _____

Floss his/her teeth daily? _____

Health History:

Please Discuss any serious medical conditions the

Child has had _____

_____

Please list all drugs the child is currently taking

_____

Child's Physician _____

Physician's Phone # __(____)_____-_____

Is your child currently under the care of a physician?

○ Yes ○ No

Please describe your child's current physical health:

○ Good ○ Fair ○ Poor

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N Allergies to any medications

Y N Allergies to Latex Product

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Birth Defects

Y N Convulsions/Epilepsy

Y N Diabetes

Y N Ear Infections

Y N Handicaps/Disabilities

Y N Hearing Impairment

Y N Heart Disease/Murmur

Y N Hemophilia/Blood Disorders

Y N Hepatitis

Y N HIV + AIDS

Y N Kidney/Liver Conditions

Y N Pregnancy

Y N Rheumatic/Scarlet Fever

Y N Tuberculosis

To help us make your child more comfortable, please list any interests or hobbies they may have _____

_____

_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent/Guardian **Date**

Office Policies

Prior to being examined by the Doctor, each patient must have a completed medical history and office policy form, signed by a custodial parent. A custodial parent must accompany their child to the dental office for treatment, or must have signed a consent form, authorizing the accompanying adult to consent to treatment.

Are you a custodial parent?_____

No Show Policy:

Appointment times are reserved exclusively for each patient, therefore we ask that you please notify our office 24 hours in advance of your scheduled appointment time if you are unable to keep your appointment. Another patient, who needs our care, could be scheduled if we have sufficient time to notify them. We realize that from time to time unexpected things happen, but we ask for your consideration and cooperation in this regard. A fee of $25.00 may be assessed on all broken appointments.

Initials _____

Missed Appointments:

After three "No Show" appointments (missed appointments without 24 hour notification) you will be dismissed from our practice. We also will notify your insurance company of the dismissal if your child is insured by Medicaid or CHIP.

Initials _____

Sibling Appointments:

At Hill Country Pediatric Dentistry, PA we understand that if you have more than one child, it is much more convenient to schedule their appointments on the same day. However, it is far easier on our staff to have them scheduled individually for their dental appointments. We will, as a courtesy to each family, agree to schedule your children at the same time, but we want to make a couple points clear to you before we do so.

1. Multiple appointments on the same day, at the same time, may not be available as quickly as individual appointments.
2. We will extend this as a courtesy to your family, however, if your family no-shows for an appointment we will not be able to offer this courtesy again.
3. If a family arrives too late for their appointment time, we may not be able to see all the children that were scheduled. For example we may be able to only accommodate 1 or 2 of the children rather than all 3.

Initials _____

Late Arrivals:

Late arrival for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. We may ask that you reschedule the appointment if you arrive more than 10 minutes late. We will try to accommodate late arrivals as time permits; however, patients arriving at their appointed time will be seen first.

Initials: _____

Wait Time:

We strive to see all patients at their scheduled appointment time. We will make every effort to see your child on time. Please remember that working with children is unpredictable, thus, we run on children's time, not adult time. Additionally, there are times when our schedule is delayed in order to accommodate an injured child or a child in pain. Please accept our apology in advance should this occur during your appointment. We will provide you the same courtesy if your child is in need of emergency treatment. Please let our front desk staff know if you have been waiting longer than 15 minutes past your appointment time.

Initials: _____

Financial Policy:

It is important to note that treatment plans presented to parents are an estimate of the out of pocket expense we expect you will incur.

Full payment is due at the time of service, regardless of who accompanies the patient on the day of his/her appointment.

If your child is covered by insurance, we file claims as a courtesy to our patients and we gladly accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out of pocket expense, however, we are required by your insurance company to collect the patient's out of pocket portion on the day of his/her appointment.

From time to time, your insurance will pay more or less than what we anticipated. In that event, you will receive a bill from us that we will expect to be paid, or you will receive a check from us if we collected too much up front.

We accept cash, checks and credit cards (Discover, Visa, MasterCard, and American Express). In addition, we offer Care Credit healthcare financing that allows for low monthly payments – please ask for details.

Checks returned for insufficient funds will be charged $30, and failure to address a returned check will result in prosecution to the full amount of the law.

Initials: _____

Accompanying Your Child for Dental Cleanings or Exams:

During a visit for a cleaning or a new patient exam it is first necessary to take x-rays, and have the hygienist clean the child's teeth. Children three and under will need to be accompanied by a parent so that we can examine the child in the parent's lap. For the safety and privacy of all patients, other children you may have with you during your visit, who are not being treated, should remain in the waiting area with a supervising adult. We ask that you allow our staff to accompany your child over three through the dental experience. We can usually establish a closer rapport with your child when you are not present. ***Of course, we want you to feel comfortable with the treatment your child is receiving so feel free to speak to one of our staff members about other options.*** Our purpose is to gain your child's confidence and help them overcome any apprehension they may have about coming to the dentist. As soon as the hygienist has finished the cleaning, you will be called back to sit with your child while we wait for the doctor to come do the exam. At this point, the doctor will visit with you about any areas of concern and provide detailed guidance where your child's dental health is concerned.

Initials: _____

Accompanying Your Child for Dental Treatment:

In the event your child is scheduled for dental treatment, we strongly encourage you to let our dental staff accompany your child through this experience. Ideally, we will have you bring your child back to our private waiting area and if your child requires sedation, this is where that will take place. Our assistants will visit with you briefly. The dental assistants will return and take your child back to the dental treatment room. For safety and sterilization reasons, we do NOT allow parents to accompany their child into the dental treatment room. We have been doing this for a very long time, and children are much more relaxed and cooperative alone. However, parents sometimes ask that they be allowed to accompany their child. You may choose to stand in the hallway with the door to the treatment room closed and observe through the window. But we would encourage you to wait in the private waiting area.

Initials: _____

Patients that fail to comply with the above policies may be subject to dismissal from Hill Country Pediatric Dentistry, PA.

Thank you for reading our office policies. Please let us know if you have any questions or concerns. We appreciate the trust and confidence you have placed in us for your child's dental care.

I have read, understand and agree to abide by the Office Policies for Hill Country Pediatric Dentistry, PA and further acknowledge that failure to comply may result in dismissal from the practice:

CHILD'S NAME: _____

_____ _____

Signature of Parent/Guardian **Date**

Pediatric Dentistry Informed Consent for Patient Management Techniques

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

ALL IN GOOD INTENTION

It is our intent that all professional care delivered in our dental office shall be of the best possible quality we can provide for each child. We believe that any dentist can get your child's work done – our mission is to do so in a manner which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life.

All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In some cases, further behavior management techniques are needed. There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. These techniques are ***not*** a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

PLEASE READ THIS FORM CAREFULLY AND ASK ABOUT ANYTHING YOU DO NOT UNDERSTAND. PLEASE INITIAL TO IDENTIFY YOU UNDERSTAND THE TECHNIQUES WE USE.

PEDIATRIC DENSTISTRY BEHAVIOR MANAGEMENT TECHNIQUES

The more frequently used pediatric dentistry behavior management techniques are as follows:

_____ **1.Tell-Show-Do:** The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

_____ **2.Positive reinforcement:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, pat on the back, a hug, or a prize.

_____**3.Voice control:** Is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.

_____**4.Mouth props/Rubber dams:** A mouth prop or "tooth pillow" as we call it is used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc). This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a "raincoat" placed on the area of work isolate the teeth and prevent any debris from being swallowed or going to the back of the throat.

_____**5.Immobilization by the dentist:** The dentist controls the child from movement by gently holding the child's hands or upper body, stabilizing the child's head between the dentist's arm and body.

_____**6.Imobilization by the assistant:** The assistant controls the child from movement by gently holding the child's hands, stabilizing the head, and/or controlling leg movements.

_____**7.Immobilization by Pedi-Wrap:** A passive restraint device, designed specifically for pediatric dental procedures, which is used when complete immobilization is needed for the safety of the patient and the dental team. It is used during most, not all, sedation procedures.

_____**8.Relaxation Gas:** Nitrous oxide and oxygen (laughing gas) may be administered to relax the child and to raise his/her pain threshold. This allows the child to sit in the chair longer, increases their attention span, and allows for more work to be done without the child labeling something as painful. **Nitrous oxide and oxygen is not general anesthesia.** The child is not "put to sleep" and does not become unconscious, only relaxed.

_____**9.Conscious Sedation:** Is recommended for mildly apprehensive and very young children. The majority of children respond very well for dental treatment. For various reasons, some children may be apprehensive about dental treatment and may require some form of conscious sedation to allow treatment.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. The listed pediatric dentistry management techniques have been explained to me.
2. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in the pediatric dental community and are merely **used only if necessary** to provide the best dental care.
3. I have been encouraged to ask questions and all questions about the patient management techniques described have been answered in a satisfactory manner.
4. I hereby acknowledge that I have read and understand this consent.
5. I acknowledge that I have not been coerced/forced to sign this consent and that I have been given the alternative to withdraw from it.
6. I hereby authorize and direct Dr. Hernandez and associate dentists of Hill Country Pediatric Dentistry, PA and Central Texas Pediatric Dentistry assisted by other dentists and/or dental auxiliaries of his/her choice, to utilize, if required, the necessary patient management techniques to assist in the provision of the required dental treatment for my child (or legal ward).
7. I understand that this consent shall remain in effect until terminated by me.

_____	_____	_____	_____
Patient Name	**Person Authorized to Consent**	**Relationship to Patient**	**Date**

HEALTH INFORMATION ACCESS

We understand that at times it is not possible for the parent or legal guardian of a child to bring him/her in for a scheduled appointment or for emergency treatment. You may give permission to others to bring your child by filling out the following form. If you leave this section blank, only a parent or legal guardian will be allowed to consent to treatment or schedule an appointment.

The following names are of people, including myself, that I would like to be involved in or have access to my child's protected health information. I give permission for Hill Country Pediatric Dentistry, PA to share my Child's protected health information with the individuals listed below.

I, as parent or legal guardian, give permission for

_____

(Name) (Relationship) (Social Security/or Drivers License)

_____

(Name) (Relationship) (Social Security/or Drivers License)

_____

(Name) (Relationship) (Social Security/or Drivers License)

_____

(Name) (Relationship) (Social Security/or Drivers License)

to obtain dental treatment. Further, I will make sure the above individual(s) are aware of the medical history of my child and can answer all questions required for safe dental treatment. In addition, I understand that treatment plan changes may occur for a variety of reasons. I understand and agree that any treatment plan that may have been explained to me is subject to change and in some cases will change the fees quoted to me. Lastly, I will make arrangements for the above individual(s) to bring any necessary insurance forms and/or payment for services rendered at each visit.

_____

Child's Name

_____ _____

Signature of Legal Parent/ Guardian Date

If you wish to add or terminate information access to or from the above list, you must submit your request in writing to:
Hill Country Pediatric Dentistry
12225 FM 2244 Ste. 100
Bee Cave, TX 78738

Hill Country Pediatric Dentistry
12225 FM 2244 Ste 100
Bee Cave, TX 78738

Dr. Steve and Dr. Angie Hernandez
www.hcpdkid.com
Office 512-263-7455
Fax 512-263-7460

We provide our patients the option to participate in our online communication system. Some of the features include the ability to:

- Request appointments online
- Confirm appointments via e-mail
- Receive text message appointment reminders
- Submit patient satisfaction surveys
- Refer your friends online

Please provide your contact information:

Name: _____

Childs Name: _____

Address 1: _____

Address 2: _____

City: _____

State: _____

Zip: _____

Home Phone: _____

Work Phone: _____

*Cell Phone: _____ *Check here to opt into text messaging* ☐

*E-Mail: _____ *Check here to opt into E-Mail* ☐

HIPAA Acknowledgement

We may disclose Patient Health Information (PHI) to third parties that perform services for Hill Country Pediatric Dentistry in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of PHI. Your PHI may be disclosed to an affiliate that performs services for Hill Country Pediatric Dentistry in the administration of your benefits. ***Our affiliates do not see, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without users permission, and do not send spam.***

Please sign below that you agree to allow us to use this information in providing your services.

_____ _____

Signature **Date**