Welcome to QN Smiles

1. Tell Us About the Patient

Child's Name ____ M ☐ F ☐ Date of Birth: ____/___/______

First *Mi* *Last*

Patient's Home Address ____ Apt ________ City ____________ Zip Code___________

Patient's home (_____) _________________ Siblings that we treat? ____

2. Legal Guardian #1 and Responsible Party Information

Name ____ Date of Birth: ____/___/______

First *Mi* *Last*

Home Address ____ Apt ________ City _______________ Zip Code ____________

Relationship to Patient_________________ SS# ________________ DL# ________________ Employer _______________________

Cell (_____) _________________ Home (_____) _________________ Work (_____) _________________

E-mail ______________________________________ How did you hear about us? __________________

3. Legal Guardian #2

Name ____ Date of Birth: ____/___/______

First *Mi* *Last*

Home Address ____ Apt ________ City _______________ Zip Code____________

Relationship to Patient_________________ SS# ________________ DL# ________________Employer _______________________

Cell (_____) _________________ Home (_____) _________________ Work (_____) _________________

E-mail ______________________________________

4. Communication consent

Consent to text messages being sent to cellphone	Yes ☐	No ☐
Consent to voicemail being left on answering machine	Yes ☐	No ☐
Consent to a message being left with a family member / Representative	Yes ☐	No ☐
Consent to emails being sent to email account	Yes ☐	No ☐

5. Dental Insurance Information

☐ No insurance (*if no insurance, skip this section*)

PRIMARY INSURANCE		**SECONDARY INSURANCE**	
Insurance Co. name:		Insurance Co. name:	
Subscriber's Name:		Subscriber's Name:	
Subscriber's date of birth:		Subscriber's date of birth:	
Member ID number or SSN:		Member ID number or SSN:	
Group number:		Group number:	
Employer:		Employer:	

Assignment and release
This signature on file is my authorization for the release of information necessary to process all insurance submissions. I hereby authorized payments to QN Smiles of the benefits otherwise payable to me.

✖ ______________________________ ✖ ____________

Signature of policy holder or authorized Individual **Date**

Assignment and release
This signature on file is my authorization for the release of information necessary to process all insurance submissions. I hereby authorized payments to QN Smiles of the benefits otherwise payable to me.

✖ ______________________________ ✖ ____________

Signature of policy holder or authorized Individual **Date**

Child's Name ____ Birth date: _____________

6. Dental Information

Is this the patient's first dental visit? Yes ☐ No ☐

If not, when was his last dental check-up? ______________ Name of previous Dentist: _____________________

Any previous injuries to the teeth, face, head or mouth? Yes ☐ No ☐

If yes, please explain: ____

What is the reason for your visit today? ____

Please check if the patient has had any of the following problems:

- ☐ Thumb / Finger Sucking
- ☐ Ice Chewing
- ☐ Tongue Thrust
- ☐ Frequent Snoring
- ☐ Tonsil Removed
- ☐ Bad Breath
- ☐ Tooth Ache
- ☐ Sensitive to Sweets
- ☐ Nail Biting
- ☐ Lip Sucking / Biting
- ☐ Mouth Breathing
- ☐ Teeth Grinding
- ☐ Adenoids Removed
- ☐ Discolored Teeth
- ☐ Bleeding Gums
- ☐ Sensitive Hot / Cold

Has the patient ever had pain in the jaw joint(s) (TMJ/TMD)? Yes ☐ No ☐
Has the patient been referred for orthodontics (braces) before? Yes ☐ No ☐
Is the patient water fluoridated? Yes ☐ No ☐
Is the patient taking fluoride supplements? Yes ☐ No ☐
Does the patient brush their teeth daily after every meal? Yes ☐ No ☐
Does the patient floss their teeth daily Yes ☐ No ☐
Does the patient have any pending dental treatment that you know of? Yes ☐ No ☐
If yes, please explain ____

Is fluoride toothpaste used? Yes ☐ No ☐
Does the child have any speech difficulty? Yes ☐ No ☐
Has the child ever had dental radiograph (x-rays) exposed? Yes ☐ No ☐
Has the child Had any problem with the eruption or shedding of teeth? Yes ☐ No ☐
Has the child had any problem with dental treatment in the past? Yes ☐ No ☐

If yes, please explain ____

Does the patient participate in active recreational activities? Yes ☐ No ☐

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issue prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

✖ ______________________________________ ✖ ____________________

Signature of Parent or Legal Guardian Date

DDS Initials: _______

Child's Name ____ Birth date: _______________

7. Medical Information

Child's Pediatrician: ______________________ Address: ____________________________ Phone: (____)_______________

Pharmacy: ______________________________ Phone: (____)_______________

	Yes	No
Is your child in good health?	☐	☐
Are your child's immunizations up to date?	☐	☐
Is your child being treated for any condition presently?	☐	☐
If so, explain: ______________________________		
Is your child taking any medications or drugs?	☐	☐
If so, explain: ______________________________		
Has your child ever been hospitalized or had surgery?	☐	☐
If so, explain: ______________________________		
Does your child have any allergies or reactions to any medications?	☐	☐
If so, explain: ______________________________		

Does your child have any allergies to the following: ☐ pollen ☐ food / food dyes ☐ dust ☐ latex
☐ Penicilin / antibiotics ☐ Local anesthesia / novocaine ☐ Sulfa drugs ☐ other ___________

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Chronic headaches	☐	☐	Hemophilia
☐	☐	Allergies to medication	☐	☐	Chronic ear infections	☐	☐	Hepatitis or liver disease
☐	☐	Anemia	☐	☐	Cleft lip / palate	☐	☐	Hyperactivity
☐	☐	Asthma / lung problems	☐	☐	Convulsion / seizures	☐	☐	Kidney disease
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Leukemia
☐	☐	Behavior / language problems	☐	☐	Endocrine system	☐	☐	Mental / emotional
☐	☐	Bladder conditions	☐	☐	Epilepsy	☐	☐	Nutritional deficiency
☐	☐	Blood transfusions	☐	☐	Eye problem	☐	☐	Oral ulcers
☐	☐	Birth defects	☐	☐	Excessive bleeding problem	☐	☐	Orthopedic problems
☐	☐	Bone or joint problems	☐	☐	Excessive gagging	☐	☐	Premature birth
☐	☐	Brain injury	☐	☐	Fainting or dizziness	☐	☐	Rheumatic fever
☐	☐	Heart problems	☐	☐	Frequent infections	☐	☐	Sickle cell anemia
☐	☐	Cancer or malignancies	☐	☐	Growth & development problems	☐	☐	Significant injury
☐	☐	Cerebral palsy	☐	☐	Hearing / speech problems	☐	☐	Syndrome: ____________
☐	☐	Child abuse	☐	☐	Bruising easily / abnormal bleeding	☐	☐	Other: ________________
☐	☐	Chronic adenoid / tonsil infection						

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information that has not been covered: ____

Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issue prior to treatment. I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

✖ ____ ✖ ___________________________

Signature of Parent or Legal Guardian Date

DDS Initials: _______

________________________________ ________________________ ______ ___________________________
Last Name First Name Middle Birthdate

Acknowledgement of Receipt of Notice of Privacy Practices

I have reviewed the office's Notice of Privacy Practices and understand that I may request a copy by email or paper for my records at any time.

✖ ____ ✖ ___________________________
Signature of Parent or Legal Guardian Date

Consent for Use or Disclosure of Patient's Protected Health Information

- I hereby authorize QN Smiles, PLLC. to release information for dental claims, prescriptions, diagnostic treatment, and care management services, and for reviews required by HHS or HIPAA-compliant operations via reasonable methods including but not limited to phone, fax, mail, electronic mail, and friend/relative/caregiver. If I provide an email address, I am able to receive email securely and away from a public computer.
- I hereby authorize the designated parties below to request and receive protected health information regarding my child's dental treatment, dental findings, billing, payment or administrative operations related to dental treatment. I understand that the identity of designated parties must be verified before the release of any information occurs. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA Privacy regulations.

Friend, Relative, and/or Caregiver who may bring your child for care and to whom QN Smiles is authorized to discuss/release my child confidential health information (Please list below):

Name ____ Relationship ______________________

Name ____ Relationship ______________________

Name ____ Relationship ______________________

Given the layout of our office, from time to time, conversations may be overheard by others. If you object to the fact that you may overhear other patient's health information, or that your child's health information may be overheard by another, please let us know and we will be sure to either place you in a completely private room or reschedule your appointment according to your needs.

CONSENT

I understand that consent may be revoked by me at any time. I understand why I have been asked to disclose this information and am aware that my child's rights are identified in the practice's Notice of Privacy Practices.

✖ ____ ✖ ___________________________
Signature of Parent or Legal Guardian Date

FINANCIAL POLICY

During your first visit we will discuss the number of visits needed for your treatment, the length of each visit, and the projected costs involved. We deliver the finest care at the most reasonable cost to our patients; therefore, **payment is due at the time service is rendered unless other arrangements had been made in advance**.

Please note that you are fully responsible for all fees charged by our office regardless of your insurance coverage.

Fees: Fees will vary greatly depending on the type of treatment needed. Fees are based on the tooth involved, the type of treatment necessary, and the extent of the treatment provided. During your consultation, we will discuss the necessary number of visits, their lengths, and the fees involved.

Patients with Dental Insurance: We will assist you to the best of our ability in obtaining the maximum benefits from your insurance and as a courtesy to you, our office will gladly submit dental claims to your insurance company. Our office does participate with a variety of Dental PPO, Texas MEDICAID and CHIP, Fee for Service Plans, Traditional Plans, Indemnity Plans and Discount Program Plans. Please check your type of plan carefully and for more specific information about benefit amounts, please call your insurance company.

Payment Options: We accept cash, check, VISA, MasterCard, American Express, Discover and Care Credit. A charge of $30 will be applied for returned checks. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%, etc.) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected but never higher that our office's UCR (Usual, Customary, and Reasonable) Fee or our contractual obligation with your insurance company whenever apply. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due on the statement receive date.

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past-Due Accounts: All delinquent accounts at QN Smiles accrue interest at the legal rate. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account and will also become the financial responsibility of the account holder.

Financial agreements: for deferred interest options we accept Care Credit. Financial agreement for Orthodontic treatments is separated from dental treatment.

QN Smiles, PLLC reserves the right to update and make changes the above-stated office policies at any time without prior notification.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered to me and my dependents (if applicable).

✖ ____ ✖ ________________________

Signature of Parent or Legal Guardian   Date

CANCELLATION AND NO-SHOW POLICY

Your time is very important to us; therefore, this office makes every effort to stay on schedule. We make certain that ample time is provided for each patient; for both office visit appointments and all of our dental procedures that are done as part of a treatment plan.

We do not overbook patients; we allow each patient the quality time and consideration necessary for their specific dental needs. We do, however, see patients with highly complex problems that often require additional time.

As you may relate to, we often have many patients requiring care who are waiting to be seen by our providers. If a patient does not provide timely notice that they will not be able to make their scheduled appointment, we will not have time to schedule another patient that, in some cases, desperately need to be seen.

For this reason, we kindly request at least 24 hours' notice prior to cancelling or rescheduling an office visit appointment and 48 hours' notice for treatment procedures.

Please note that **we reserve the right to charge your account:**

- **$25 for missed appointment.**
- **$25 for late cancellation.**

We value your time and expect the same courtesy in return. additionally, **the office reserves the right to revoke appointment privileges for non-compliance patients.** We understand that unforeseen event might happen and a late cancelation not always can be avoided and therefore we will give a first warning before enforcing this clause.

So, please notify our office in advance during regular business hours if you need to cancel or reschedule your appointment according to the timeframes listed above.

QN Smiles reserves the right to update and make changes to the above-stated office policies at any time without prior notification.

By signing below, I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for me and my dependents accounts (if applicable).

Thank you for your understanding and cooperation.

✖ ______________________________

Signature of Parent or Legal Guardian

✖ ______________________________

Date