# Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

**Caldwell and Steinbring, D.D.S.**

## Tell Us About Your Child

**Today's Date** _____

**Name** _____

Preferred Name _____ ☐ Male ☐ Female

Child's Birth date ___/___/___ Child's Age _____

**Child's Home Address**

_____
Apt/Condo #

_____
City State Zip

## Who is Accompanying the Child Today?

Name _____

Relationship _____

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

Is your child adopted? ☐ Yes ☐ No

Other family member(s) seen by us _____

Parent's Marital Status ☐ Single ☐ Widowed
☐ Married ☐ Divorced ☐ Separated

**Please circle the phone number that you would like us to call or text to confirm all appointments.**

## Mother's Information ☐ Step-Mother ☐ Guardian

Name _____

Work# _____ Ext ____ Home# _____

Employer _____

Cell# _____ SS# _____

Date of Birth _____

**Must have one social security number on file for our billing purposes.**

## Father's Information ☐ Step-Father ☐ Guardian

Name _____

Work# _____ Ext ____ Home# _____

Employer _____

Cell# _____ SS# _____

Date of Birth _____

## Name of Nearest Relative

Name _____

Work# _____ Ext ____ Home# _____

## Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship to Patient _____

Insured's Birth date ___/___/___ ID# _____

Insured's Employer _____

**Please provide us with your *E-MAIL ADDRESS*: This is how we send appointment reminders.**

_____

**Would you like to receive email statements?**

☐ **Yes** ☐ **No**

**How did you hear about our office?**
(please check all that apply)

☐ Pediatrician _____

☐ Orthodontist _____

☐ General Dentist _____

☐ Magazine Ad _____

☐ Tillie Program; School _____

☐ Friend _____

☐ Insurance _____

☐ Internet _____

☐ Other _____

_____

_____

## Medical History

Reason for today's visit _____

Has the child ever had a bad experience with dental work? ☐ Yes ☐ No

Is the child ***Delayed Average Advanced*** in social development? Please circle one.

How would you describe the child's personality/temperament? Circle all that apply:

***Cooperative Uncooperative Sensitive Apprehensive Well-adjusted Aggressive Shy***

Previous dentists' name and phone number _____

Last Date Seen _____ X-rays _____

Is your child's drinking water fluorinated? ☐ Yes ☐ No

Is your child taking vitamins with fluoride supplements? ☐ Yes ☐ No

How many times a day are your child's teeth brushed? _____

Is the child currently using a bottle? ☐ Yes ☐ No How often? _____

Current dental habits. Please circle: ***Thumb or Finger Sucking Use of Pacifier Lip or Cheek Biting Nail Biting***

Previous or current TMJ (jaw) pain, tenderness or popping? _____

Does the child have or ever had recurring headaches? ☐ Yes ☐ No

Has the child ever had any of the following medical conditions? Please circle all that apply.

***Y N*** Cancer/Tumors
***Y N*** Asthma/Breathing Problems
***Y N*** Congenital Heart Defects
***Y N*** Gastro Intestinal Problems
***Y N*** Diabetes
***Y N*** Frequent Infections
***Y N*** Hepatisis
***Y N*** Rheumatic Fever
***Y N*** Liver Or Kidney Disorder
***Y N*** Seizures/Epilepsy
***Y N*** Endocrine System
***Y N*** Hemophilia/Bleeding Disorders
***Y N*** Tuberculosis
***Y N*** Sight Impairments
***Y N*** Lung or Respiratory Problems
***Y N*** HIV/AIDS
***Y N*** Hearing Impairments

History of blood transfusions? ☐ Yes ☐ No Date _____

Does the child have a heart murmur or condition that requires ***Prophylactic Antibiotic coverage for dental work?***
☐ Yes ☐ No

Please list all medications the patient is currently taking _____

Please list any medical conditions that the child has had past or present _____

Hospitalizations or injuries _____

Please list all drugs the child ***is allergic to*** _____ Other allergies _____

Does the child have seizures? ☐ Yes ☐ No Are the seizures related to high fever? ☐ Yes ☐ No

Does the child have any behavioral or learning disabilities? _____

Developmentally Delayed? ☐ Yes ☐ No Skill Level _____

Physical Disabilities _____

Any other significant problems or comments _____

_____

Has the child had any recent infections of bacterial or viral origin? ☐ Yes ☐ No

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's Physician _____ Phone _____Date Last Seen _____

***Because your child is a minor, it is necessary that signed permission be obtained from a parent or guardian before and/or all necessary dental treatment is performed. Diagnosis of services needed and financial obligations will be discussed with you by the doctor and/or staff before treatment is rendered. Your signature authorized Dr. Caldwell and/or his Pediatric Dentist Associate to render necessary dental treatment, to administer anesthetics, to administer medication, to take radiographs (X-rays), clinical photographs, study models and other records necessary for an accurate diagnosis, to utilize behavior management therapy as needed to provide safe dental care for your child and employ such assistance as is appropriate.***

Signature of parent or guardian _____ Date _____

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CEC and the ADA.**

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials____ Date _____

Doctor's Comments _____

Doctor's Comments

**Caldwell and Steinbring**
**Dentistry for Children**

*15200 Southwest Freeway, Suite 320*
*Sugar Land, TX 77478*

## Office Policies

The person accompanying the patient is responsible for the account regardless of who carries the insurance on the patient.

We request that the person accompanying the child not leave the premises until the appointment is over, in the event a question arises regarding the child's appointment.

A broken appointment is a loss to everyone. As a courtesy, please allow a **24 hour** notice for any schedule changes.

The practice, as a courtesy, will accept and file your insurance for you, HOWEVER, WE ARE NOT A PARTICIPATING PROVIDER ON MANY DENTAL PLANS, THIS MEANS YOU ARE RESPONSIBLE FOR THE DIFFERENCE BETWEEN OUR FEE AND THE INSURANCE ALLOWABLE FEE.

THE ONLY HMO/DMO WE ARE AFFILIATED WITH IS CIGNA (AGE LIMIT IS UNDER 7 YEARS OLD). IF YOU HAVE AN HMO/DMO, THEN YOUR INSURANCE WILL NOT PAY OUR OFFICE. I am aware that insurance will cover an estimated percentage of most dental procedures and the portion that is not covered by insurance is due at the time services are rendered, unless other financial arrangements have been made prior to the dental appointment.

I am aware that some procedures are subject to a deductible and if it has not been met then I will pay this at the time services are rendered, unless other financial arrangements have been made prior to the dental appointment.

If you have secondary insurance (two DENTAL plans), it does not necessarily mean that these combined insurance will cover your services 100%. It is up to you, the insured, to know how the two dental plans will coordinate benefits. **We do not file secondary insurance.**

I hereby agree to assign all insurance payments to Caldwell and Steinbring, PLLC. I am aware that my insurance company may not cover all of the professional fees. I hereby agree to pay, within **30 days**, any outstanding balance following payments by the insurance company unless other financial arrangements have been made.

I agree that if the insurance fails to pay Caldwell and Steinbring, PLLC within (60) days of the rendering treatment all fees are due and payable at that time.

In the event the insurance company pays you the patient instead of Caldwell and Steinbring, PLLC, I agree to forward the payment to Caldwell and Steinbring, PLLC.

In the event a check is returned from a financial institution, a return check fee of $20.00 will be applied. In the event of default, I promise to pay legal interest on the indebtedness together with such collection costs as may be required to effect the collection of this note.

Due to privacy policies, we do not allow cell phone or camera usage in our treatment areas. You may use your phone in the waiting areas.

**We are now offering email statements-Would you like to receive your statement this way? YES___NO___**
**Please make sure we have a valid email address.**

SIGNATURE: _____ DATE: _____

# Caldwell and Steinbring
# Dentistry For Children

*15200 Southwest Freeway, Suite 320*
*Sugar Land, Texas 77478*

## Behavior Management Policy

Providing quality dental care for children requires expertise in directing child behavior. Our goal is to instill in the child, a positive attitude towards dentistry. Maintaining proper behavior of children while in the dental office demands skill of verbal guidance, prevention of inappropriate actions, and reinforcement of appropriate behavior. These techniques are used only for behavioral modification and not to reprimand or punish a child.

The following are various behavior management techniques used in this office.

- Positive Reinforcement: Social reinforcers such as verbal praise and non-social reinforcers such as rewards (toys, stickers).

- Tell-Show-Do: Explain procedures and instruments to the child with the use of modified terms such as "sleepy juice," "water whistle," and "wiggle tooth" rather than "shot," "drill," and "pull tooth."

- Distraction: Use of distraction to divert the patients' attention from what he/she may perceive as unpleasantness.

- Voice Modification: Change of voice volume or tone to gain a child's attention and direct his/her behavior.

- Nitrous Oxide/Oxygen Sedation: This is a very safe and effective conscious sedation method which is easily monitored. The onset of this sedation is quick and recovery is fast and complete before the child leaves the office.

- Pediwrap or Papoose: Partial or complete immobilization with the use of a blanket type wrap, is sometimes necessary to protect the child from injury while using dental instruments. This technique is only used in cases when it has been determined that all other forms of behavior management have not or will not be effective.

It is our office policy to minimize the use of more extreme forms of behavior management techniques and to implement them only when necessary.

SIGNATURE:_____ DATE:_____

# Caldwell and Steinbring
# Dentistry For Children

*15200 Southwest Freeway, Suite 320*
*Sugar Land, Texas 77478*
*(281) 565-5437*

Dear Parent,

We accept and file dental insurance as a courtesy to our patients. We try to know all aspects of your dental plan. Any treatment outline that we present to you is just an **ESTIMATE** and not a guarantee of benefits. When we call to verify benefits, the insurance company informs us that, "this is not a guarantee of benefitsuntil they actually receive the claim and process it."

We file a pre-estimate to your insurance for some procedures such as orthodontic appliances, crowns, surgical procedures and large cases. We do not submit pre-estimates for every procedure but, at your request, we will gladly do so. It normally takes 3 to 4 weeks to receive an estimate back from an insurance company.

**In-Network versus Out-of-Network PPO Insurance**

When you have a PPO you can go Out-of-Network and the insurance will pay our office. What does this mean? In-Network means that we have a contract with your insurance company and we agree to accept their fees. Out-of-Network means we DO NOT have a contract with your insurance and we do not accept the fee that your insurance allows and you are responsible for the difference between ourfee and the allowable fee from your insurance. We will not adjust off the difference between the two.

**HMO/DMO Insurance**

When you have an HMO/DMO, then you have to go to a doctor that accepts your insurance; you cannot go Out-of-Network. The only HMO/DMO that we are on is CIGNA (age limit is under 7 years).

It is very beneficial, as the insured, to know your dental plan.

**Common questions to Ask Your Insurance Company**

- What is the frequency of exams, cleanings and fluoride?
- Is there an age limit for fluoride treatments?
- Are sealants a covered benefit? If so, what is the age limit?
- Do I have orthodontic benefits?
- Do you have a waiting period with your insurance plan?

Most insurance companies will tell you how they will cover a procedure if you give them the ADA code, which is on the treatment outline.

SIGNATURE:_____ DATE:_____

## Caldwell and Steinbring
## Dentistry For Children

# ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgment****

I, _____ _____ , have received a copy of this office's ***Notice of Privacy*** Practices

_____
**Please Print Name**

_____
**Signature**

_____
**Date**

## For Office Use Only

We attempted to obtain written Acknowledgment of receipt of our ***Notice of Privacy Practices***, but Acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

# CONSENT TO USE ELECTRONIC COMMUNICATIONS

## DENTIST INFORMATION:

Name: Larry Caldwell DDS and Derek Steinbring DMD MS

Address:15200 SW FRWY #320

Sugar Land, TX 77478

Email: cskidsdds.com

Phone: 281-565-5437 Fax: 281-565-6446

Website: cskidsdds.com

The Dentist has offered to communicate using the following means of electronic communication [check all that apply]:

| | |
|---|---|
| ☐ Email | ☐ Videoconferencing (including Skype®, FaceTime®) |
| ☐ Text messaging (including instant messaging) | ☐ Leave Voice Message relating to appt.reminders,billing, etc |
| ☐ Social media : | |
| ☐ Other (specify): | |

## PARENT ACKNOWLEDGMENT AND AGREEMENT:

| |
|---|
| Patient name: |
| Patient address: |
| Patient home phone: |
| Parent mobile phone: |
| Parent email: |

| | |
|---|---|
| Parent signature: | Date: |
| Witness signature: | Date: |