CATHERINE JUDD DDS

PEDIATRIC DENTISTRY

4701 OLD SHEPARD PLACE/ SUITE 120 / PLANO, TEXAS 75093 / 972-596-5203

PERSONAL INFORMATION

Date _____ **PARENT'S EMAIL**_____

Patient's Name _____ Name Used _____ Age _____
First Middle Last

Name of child's favorite pet/hobby/playmate _____ Date of Birth _____

Address _____ Home Phone _____
Street City Zip

How long at this address? _____ If less than 5 years, list previous address below:

Address _____
Street City Zip

Father's First/Middle/Last Name _____

Date of Birth _____ Social Security Number _____ Employer _____

Occupation _____ Work Phone _____ Cell Phone _____

Mother's First/Middle/Last Name _____

Date of Birth _____ Social Security Number _____ Employer _____

Occupation _____ Work Phone _____ Cell Phone _____

With whom does patient live? _____

DENTAL INSURANCE INFORMATION

Dental Insurance Company _____ Telephone Number_____

Claims Mailing Address _____ State _____ Zip _____

Subscriber Name _____ Employer _____ Relationship to Patient _____

ID Number/ Subscriber Social Security Number _____ Group# _____Date of Birth _____

Subscriber's Address (if different than patient) _____

DENTAL HISTORY

REASON FOR VISIT _____

Family Dentist _____ Referred by _____

1. Does/did your child take a bottle to bed at night? Yes/No Age Discontinued _____
2. Does your child use fluoride other than toothpaste at home? Yes/No What? _____
3. Does your child suck his thumb/finger/pacifier? (please circle) Yes/No
4. Does your child have a toothache? Yes/No
5. Is this your child's first visit to the dentist? Yes/No

   If no, date of last dental examination _____ Name of dentist _____

   Date of last dental X-rays _____
6. Has your child experienced any unfavorable reaction from any medical or dental care? Please explain:

_____

-PLEASE CONTINUE ON BACK-

ORAL HYGIENE

I always/sometimes/never supervise my child's brushing. Tooth brushing is completed _____ times a day.

Do you ever notice that your child eats or swallows toothpaste? Yes/No Name of child's tooth paste _____

Name of child's fluoride supplement (if applicable) _____

FAMILY DENTAL HISTORY

Mom/Dad has history of frequent dental treatment? _____

Mom/Dad has weak teeth? _____

Mom/Dad has cavities as an adult? _____

Mom/Dad has congenitally missing teeth? _____

HEALTH HISTORY

Child's Physician _____ Phone _____

Date of last medical exam _____

CHECK ANY OF THE FOLLOWING THAT MAY PERTAIN TO YOUR CHILD:

_____ Anemia	_____ Cleft Lip / Palate	_____ Hearing Loss	_____ Developmental Delays
_____ Attention Deficit Disorder	_____ Convulsions / Seizures	_____ Heart Disease	_____ Nutritional Deficiency
_____ Allergy	_____ Diabetes	_____ Hemophilia	_____ Orthopedic Problem
_____ Asthma	_____ Emotional Disturbance	_____ Hepatitis—Type _____	_____ Rheumatic Fever
_____ Autism	_____ Epilepsy	_____ Heart Murmur	_____ Sickel Cell Anemia
_____ Brain Injury	_____ Eye Problems	_____ Hyperactivity	_____ Spina Bifida
_____ Cancer	_____ Excessive Bleeding Problem	_____ Jaundice	_____ Syndrome
_____ Cerebral Palsey	_____ Fainting	_____ Leukemia	_____ Other

_____ Child is in good health / None of the above

Explain any items checked above:

_____

1. Has your child **ever been hospitalized**? Yes/No _____
2. Is your child up to date with immunizations? Yes/No _____
3. Is your child **allergic to any medications**? Yes/No _____
4. Is your **child taking any current medications**? Yes/ No _____
   _____
   _____
   _____
5. Is your child **allergic to latex**? Yes/No
6. Have you ever been told that your **child needs premedication for a heart condition before dental treatment**? Yes/No If **Yes**, Explain:

_____
_____
_____

_____ _____ _____

Signature of person completing form **Relationship to patient** **Date**

Catherine Judd, DDS
4701 Old Shepard Pl., Suite 120
Plano, Texas 75093
Phone: 972-596-5203
Fax: 972-612-6959

Financial Agreement

Thank you for choosing our office to be your dental home. Dr. Judd and her staff are committed to providing the best quality dental care for your child(ren). In order to eliminate any confusion or miscommunication regarding your account and financial obligation to Catherine Judd, DDS, we ask that you read, understand and agree to the following terms and conditions:

INSURANCE: Your dental insurance coverage is a contract between you, your insurance provider and in most cases your employer. Catherine Judd, DDS is not a third party to, nor in any way connected to your insurance coverage or provider. We are not under nor entered into any contractual obligation with your insurance provider. ***We are out-of-network with all insurance companies***. We will attempt to file with your primary insurance as a courtesy to you and credit your account should we receive any payment. ***We do not file any secondary insurance***. Knowing your insurance benefits including but not limited to - eligibility, covered benefits, deductibles and maximums is ***your responsibility***. We will attempt to help you understand your plan and benefits, but we are limited by what the insurance companies will share with us. Should you have any questions regarding your insurance coverage please contact your insurance company's customer service department. ***You are responsible for any and all charges not covered by your insurance.***

- **Proof of Insurance:** Patients are responsible for providing current and accurate insurance information. ***Please notify us of any changes to your insurance coverage prior to any services being rendered.*** Catherine Judd, DDS is not responsible for any untimely filings or balances owed which are the result of incorrect or cancelled insurance information being provided to us. If the insurance policy cannot be verified, has expired or is an in-network policy only, then the patient will be responsible for the balance in full. Should your claim be denied, we will do our best to help you fix any issues and get the claim paid as long as it is accomplished in a timely manner.

_____(Initials)

- **Delta Dental:** Delta Dental's policy on most of their dental insurance plans is to ***not*** send payment to an out-of-network provider. Instead payment is sent to you the primary subscriber. For this reason, if Delta Dental is your insurance provider, we will collect in full for any and all services rendered at checkout on the day of your visit. Should Catherine Judd, DDS happen to receive the Delta Dental insurance check payment for your visit, we will credit the payment to your account and send you a refund check in the mail. Once it has been established that Delta is sending payment to Catherine Judd, DDS under your specific plan, then we will treat all future visits according to our normal checkout collection procedures.

_____(Initials)

- **Co-payments, Deductibles and Estimations:** All co-payments, deductibles and estimations of what insurance is not going to cover will be due and payable to us at checkout on the day that services are rendered. We do our best to estimate what insurance is going to pay, but **it is only an estimate.** The exact full amount can only be determined after the receipt of insurance payments. If there is a balance on your account after insurance pays, we will send you a statement. Please pay your balance promptly. If you end up with a credit on your account in an amount above $15, we will mail you a refund check. All credits below $15 will remain in your account to be credited towards future visits. Patient may put in a special request to receive a credit below $15.

  _____(Initials)

- **Claims Submission:** We will submit your insurance claims and assist you in any way we can to help you get your claim paid. Your insurance company may request information in order for the claim to be processed. It is your responsibility to comply with their request and provide that information to them in a timely manner. Catherine Judd, DDS may also need more information from you in order to get your claim paid. Failure to respond to our request or that of the insurance company will result in an unpaid claim and your balance due in full.

  _____(Initials)

- **Out-of-Network:** Please be aware that our office is out-of-network with all insurance companies. It is your responsibility to understand the terms of your insurance plan prior to your appointment. If your policy does not provide out-of-network benefits, then you will be responsible at checkout for the balance in full for all services rendered on the day of your visit.

  _____(Initials)

- **Payments and Balances:** We accept cash, checks, Visa, Master Card, Discover, American Express and Care Credit. If you receive a statement in the mail, you may return payment in the envelope provided, pay online via our website or call us and we can take a credit card payment over the phone. If our office does not receive payment in a timely manner, the account will be sent to collections. The responsible party on the account or primary account holder is responsible for any balances owed. The responsible party will be the person submitted to collections should the account become delinquent. Providing the primary account holder's social security number to Catherine Judd, DDS is required to open an account. Scheduling future appointments before a balance has been paid in full will be at our discretion.

  _____(Initials)

- **Returned Checks:** We will immediately notify you should we receive a "not sufficient funds" check back from the bank. Payment in full of all balances including bank fees will be due immediately upon notification or we will be forced to report the incident to the appropriate authorities. Please be advised that accepting future checks for your payments will be at the discretion of Catherine Judd, DDS.

  _____(Initials)

- **Divorce:** In the case of divorced or separated parents, it is not the responsibility of Catherine Judd, DDS to abide by a divorce decree or to figure out which parent is responsible for what payments. All divorced or separated parents will be expected to abide by the terms of this financial agreement. There will be only one parent listed on the account as the responsible party. This person will be responsible for all balances owed on the account and will be the person submitted to collections should the need arise. Please expect and prepare to make payments at checkout on the day services are rendered for any and all charges incurred. It is the responsibility of the parents to figure out all payment arrangements and to collect any monies owed to each other after the account has been settled here with Catherine Judd, DDS.

_____(Initials)

I have read and fully understand my financial obligations and the financial policy of Catherine Judd, DDS. I agree to be bound by its terms and understand that such terms may be amended periodically as needed by Catherine Judd, DDS. I also understand that I will be fully responsible for payment of any and all dental services denied by my insurance provider, as applicable by state and/or federal law.

_____ _____

Signature of Responsible Party **Date**

_____

Please Print Name of the Signature Above

Catherine Judd, DDS
4701 Old Shepard Pl., Suite 120
Plano, TX 75093
Phone: 972-596-5203
Fax: 972-612-6959

APPOINTMENT CANCELLATIONS / LATE AND NO-SHOW POLICY

We understand extenuating circumstances may prevent you from being present at your scheduled appointment. However increasing numbers of missed and late appointments are negatively impacting our ability to provide excellent care to all of our patients.

It is for this reason that we are requiring a minimum 24 hour advanced notice should you need to cancel or reschedule your appointment for any reason. Any cancelled or rescheduled appointment that does not meet our 24 hour requirement and missed or "no-show" appointments will result in a fee being charged to your account.

$30 – All non-treatment appointments

$55 – Treatment appointments

Additionally, we ask that as a courtesy you contact our office if you are going to be late for your appointment. Should you happen to arrive **15** minutes or later past your scheduled appointment time, we will need to reschedule you for another day and the missed appointment fee will apply.

It is our goal that this policy will reduce wait times and increase efficiency so that we may better serve you and your child(ren) with safe and quality dental care.

Please sign and date:

_____ _____

Signature of Responsible Party **Date**

_____

Please Print Name of the Signature Above

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____ Patient Name: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____
Please ***print*** name of Patient Please ***sign*** Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe) _____

Signature of Privacy Officer _____