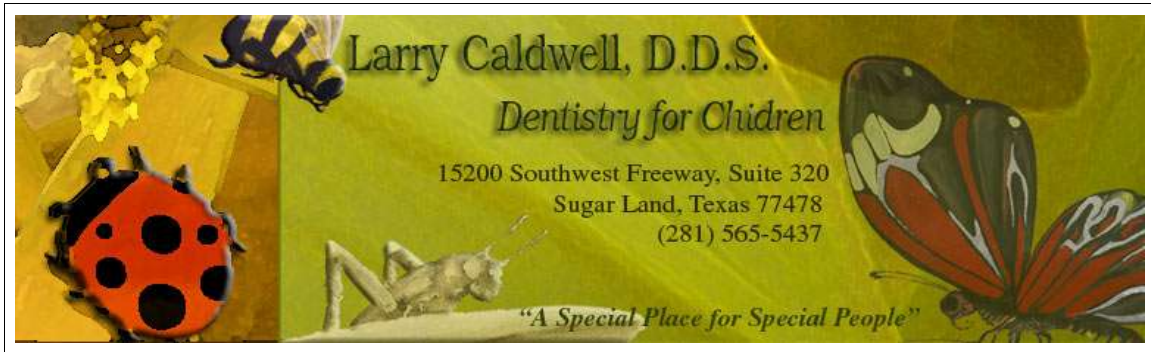


Welcome to Larry Caldwell, DDS






Dentistry for Children

*15200 Southwest Freeway, Suite 320
Sugar Land, Texas 77478
(281) 565-5437
Fax: (281) 565-6446*



Be sure to complete front and back and bring with you on your first visit. You may mail them if you like and we can get your insurance verified before your appointment. Please call if you have any questions.

The packet includes the following:

-  [Welcome Form](#)
-  [Office Policies](#)
-  [Behavior Management Policy](#)
-  [Dental Insurance Considerations Letter](#)
-  [Acknowledgement of Receipt of Notice of Privacy Practices](#)



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.

Larry Caldwell, D.D.S.
& Associates



Tell Us About Your Child

Person Responsible for Account

Today's Date _____

Name _____
Last First MI

Preferred Name _____ Male Female

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

School _____ Grade _____

Child's Home# _____

Child's Home Address _____

_____ Apt/Condo# _____

City State Zip

Name _____

Billing Address _____

Work# _____ Ext ___ Home# _____

Employer _____

DL# _____ SS# _____

Name of Nearest Relative

Name _____

Work# _____ Ext ___ Home# _____

Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

Is your child adopted? Yes No

How did you hear about our office? _____

Other family member(s) seen by us _____

Parent's Marital Status Single Widowed
 Married Divorced
 Separated

Mother's Information Step-Mother Guardian

Name _____

Work# _____ Ext ___ Home# _____

Employer _____

Cell# _____ SS# _____

Date of Birth _____

Father's Information Step-Father Guardian

Name _____

Work# _____ Ext ___ Home# _____

Employer _____

Cell# _____ SS# _____

Date of Birth _____

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 ___/___/___ SS# _____

Insured's Employer _____

Orthodontic Coverage? Yes No

So that we may better serve you, please provide us with an email address: _____





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 problems? Please circle all that apply.

- | | | |
|---------------------------------------|-------------------------------------|---|
| Y N Cancer/Tumors | Y N Hepatitis | Y N Tuberculosis |
| Y N Asthma | Y N Rheumatic Fever | Y N Sight Impairments |
| Y N Congenital Heart Defects | Y N Liver Or Kidney Disorder | Y N Lung or Respiratory Problems |
| Y N Gastro Intestinal Problems | Y N Convulsions/Epilepsy | Y N HIV/AIDS |
| Y N Diabetes | Y N Endocrine System | Y N Hearing Impairments |
| Y N Frequent Infections | Y N Hemophilia | |

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 any serious medical problems that the child has had _____

Hospitalizations or injuries _____

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

Please list all drugs the child is currently taking _____ Dose _____

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

Does the child experience an aura before seizure? Yes No Are the seizures related to high fever? Yes No

Does the child have any behavioral or learning disabilities? _____

Mental Retardation? Yes No Skill Level _____

Handicaps/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 any/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 _____

Larry Caldwell, D.D.S.

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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.

Dr. Caldwell, as a courtesy, will accept and file your insurance for you, HOWEVER, WE ARE NOT A PARTICIPATING PROVIDER ON ANY 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 insurances 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 Dr. Larry Caldwell. 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 payment by the insurance company unless other financial arrangements have been made.

I agree that if the insurance fails to pay Dr. Larry Caldwell 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 Dr. Larry Caldwell, I agree to forward the payment to Dr. Larry Caldwell.

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.

SIGNATURE: _____ DATE: _____

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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 “wobble 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: _____

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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 benefits until 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 our fee 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: _____

Larry Caldwell, D.D.S.

**ACKNOWLEDGEMENT 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)
-
-
-
-

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