LINDA A. STEELE, DDS

We make smiles shine!

Please complete this form thoroughly. Your answers help us to know your child better.

Patient name (first/middle/last)						Preferred Name (if any)
Birth Date (M/D/Y)	Age	Weight	Sex at Birth	Current Gender Identity	Grade	School
Siblings name(s) and age(s)						Pets
Hobbies/Sports/Other interests				Whom may we thank for referring you?		

Medical History

Please circle Y or N for each question below:

Pediatrician's Name _____ Phone _____ Date of Last Physical _____

Is your child under the care of the Pediatrician now? Y N If yes, please explain _____

Is your child under the care of a specialist? Y N If yes, Name _____ Phone _____

Is your child taking any drugs or medications? Y N If yes, please list ALL _____

_____

Has your child ever been hospitalized? Y N Please list **ALL** and year _____

Has your child ever had surgery? Y N Please list **ALL** and year _____

Is your child allergic to any medications? Y N If yes, please list _____

Is your child allergic to latex? Y N

Does your child have any other known allergies? Y N If yes, please list _____

Is your child current on immunizations? Y N

Has your child had any history of or difficulty with any of the following?

- ❑ADD/ADHD
- ❑AIDS/HIV
- ❑Alcohol Abuse
- ❑Allergies
- ❑Anemia
- ❑Artificial Joints
- ❑Aspergers Syndrome
- ❑Asthma
- ❑Autism
- ❑Behavioral Problems
- ❑Bladder Disorder
- ❑Blood Disorder
- ❑Cancer
- ❑Cerebral Palsy
- ❑Cystic Fibrosis
- ❑Convulsions
- ❑Epilepsy
- ❑Excessive Bleeding
- ❑Fainting
- ❑Headaches
- ❑Head Injuries
- ❑Hearing Problems
- ❑Heart Condition
- ❑Heart Murmur
- ❑Hemophilia
- ❑Hepatitis
- ❑High Blood Pressure
- ❑Kidney Disease
- ❑Liver Disease
- ❑Lung Problems
- ❑Measles
- ❑Mental Disorders
- ❑Mononucleosis
- ❑Mumps
- ❑Nervous Disorders
- ❑Pacemaker
- ❑Pregnancy
- ❑Pulmonary Stenosis
- ❑Radiation Treatment
- ❑Respiratory Problems
- ❑Rheumatic Fever
- ❑Sensory Integration Disorder
- ❑Shunt
- ❑Sinus Problems
- ❑Skin Condition
- ❑Speech Problems/Therapy
- ❑Surgeries (explain below)
- ❑Thyroid Disease
- ❑Tuberculosis
- ❑Tumors
- ❑Ulcers

If you have selected any conditions or alerts above for your child, please clarify/explain and provide the treating Dr's name :

_____

_____

_____

_____

Are there any other medical concerns to discuss? _____

_____

_____

Dental History (Please circle Yes or No Questions Below)

Is this your child's 1st dental appointment? Y N

If no, previous dentist's name: _____ Phone: _____

Date of last visit _____ Cleaning Y N X-Rays Y N Sealants Y N Date of last Xrays _____

Has your child complained of dental problems or pain? Y N If so, please explain:_____

_____

What is the chief concern for your visit with us today? _____

Does your child brush daily? Y N How many times? _____

Does your child floss daily? Y N How many times? _____

Does your child take fluoride in any form? Y N What form? _____

Does your child eat a well-balanced diet? Y N

Has your child had any injuries to mouth/head/teeth? Y N If yes, Please explain: _____

_____

Does your child wear a mouthguard while playing sports? Y N

Is there a family history of missing or extra teeth? Y N If yes, please explain: _____

Do you have orthodontic concerns? Y N If yes, please explain _____

Is your child currently in orthodontic treatment? Y N If yes, please list name of orthodontist _____

Has your child had any unhappy dental experiences? Y N If yes, please explain _____

_____

Personal and Dietary History

Was your child born ❑Pre Term ❑Full Term

Was your child breast or bottle fed? ❑Breast ❑Bottle

Did your child have problems feeding as an infant? Y N If yes, please explain _____

Is your child a noisy eater? Y N If yes, please explain _____

Has your child ever had a lip release? Y N Tongue Tie Release Y N

Does your child snore? Y N Grind their teeth at night? Y N

Has your child had their tonsils removed? Y N Adenoids? Y N

Does your child wet the bed? Y N

Is your child a mouth breather? Y N

Does your child gag easily? Y N Drool? Y N

Does your child's jaw pop? Y N Get stuck? Y N

If you answered **YES** to any of the questions above, please explain _____

_____

Does your child have any of the following habits? ❑Thumb Sucking ❑Sleeps with a bottle ❑Bits Nails ❑Pacifier ❑Other _____

How long has your child had these habits? _____

What form of water does your child drink? ❑Tap ❑Bottled

What types of snacks does your child eat on a regular basis?_____

Consent for Treatment

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

Signature: _____ Date: _____

Child's Home Address		
Address	City, State	Zip Code

Father's (or Legal Guardian) Information	Please circle one: Single Married Divorced Widowed	
Name	First	Last
Address (if different than child)		
Home Phone		
Work Phone		
Cell Phone		
Email Address		
Social Security Number		
Date of Birth		

Mother's (or Legal Guardian) Information	Please circle one: Single Married Divorced Widowed	
Name	First	Last
Address (if different than child)		
Home Phone		
Work Phone		
Cell Phone		
Email Address		
Social Security Number		
Date of Birth		

Dental Insurance Information		
Primary Subscriber/Cardholder Name		Plan Phone Number
Plan Name	Group #	Subscriber ID#
Name of Employer		

Insurance Authorization

I certify that my minor/child is covered with the stated insurance and assign directly to Dr. Linda A. Steele all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent/guardian	Today's date

PATIENT NAME:_____ **PATIENT AGE:**_____

The importance of nasal breathing and quality sleep can affect the overall health of a pediatric patient. Dr. Linda recognizes these issues that can lead to your child having a compromised airway and impaired jaw growth.
Please provide answers to the following questions to help Dr. Linda screen for possible "Red Flags" and allow her to make recommendations to promote optimal growth of the mouth and face of your child.

Please answer **YES/NO**, or leave blank if unsure. Provide any additional information as desired.

1. When sleeping, does your child ever snore? __ YES __ NO _____
2. When sleeping, does your child ever appear to stop breathing? __ YES __ NO _____
3. When sleeping, does your child ever gasp or wake with a startle? __ YES __ NO _____
4. When sleeping, is your child's body ever in odd positions? __ YES __ NO _____
5. When sleeping, does your child have their head extended back? __ YES __ NO _____
6. When sleeping, does your child grind their teeth? __ YES __ NO _____
7. When sleeping, does your child sweat more than usual? __ YES __ NO _____
8. When sleeping, does your child breathe with their mouth open? __ YES __ NO _____
9. When sleeping, does your child leave drool on the pillow? __ YES __ NO _____
10. Does your child have difficulty getting to sleep? __ YES __ NO _____
11. Does your child have difficulty staying asleep? __ YES __ NO _____
12. Does your child wake up then have trouble going back to sleep? __ YES __ NO _____
13. Does your child sleep lightly and are they easily roused? __ YES __ NO _____
14. Does your child wake up groggy and/or moody? __ YES __ NO _____
15. Does your child wake up with a head-ache? __ YES __ NO _____
16. Does your child appear lethargic or hyperactive during the day? __ YES __ NO _____
17. Does your child have nightmares? __ YES __ NO _____
18. Does your child sleep walk or talk? __ YES __ NO _____
19. Does your child toss and turn while asleep? __ YES __ NO _____
20. Does your child have problems with anxiety or behavioral issues? __ YES __ NO _____
21. Does your child have fidgety legs? __ YES __ NO _____
22. Does your child wake up in a tangle of bedclothes or on the wrong side of the bed? __ YES __ NO _____
23. Does your child chew with mouth open/messy eater? __ YES __ NO _____
24. Does your child exhibit thumb sucking or chewing on foreign objects (pencil, nail, hair)? __ YES __ NO _____

26. How many hours of sleep does your child get, on average, in a 24 hour period , including naps? (Please circle)

Less than 6 6-7 7-8 8-9 9-10 10-11 11-12 13-14 15-17

National Sleep Foundation Recommended Sleep Times

Toddlers (1-2 years)	11-14 hours
Preschoolers (3-5 years)	10-13 hours
School aged children (6-13 years)	9-11 hours
Teenagers (14-17 years)	8--9 hours

LINDA A. STEELE, DDS
Dentistry for infants*children*teens
Lights. Camera. Smile!
225 East State Highway 121
Suite 150
Coppell, Texas 75019
972.315.3355
www.drlindasteele.com

LINDA A. STEELE, DDS

Cancellation Policy

We at Dr. Linda's office take pride in our warm and caring atmosphere. One aspect we enjoy is the opportunity to offer quality care and individual attention to each and every patient. When that time is lost due to an appointment cancellation, other patients in need of treatment cannot be seen and our time is not used efficiently. For these reasons, we have implemented the following cancellation policy effective April 15, 2009

We request a 24-hour notice to either change or cancel your child's appointment. Failure to do so may/will result in $50 charge and is at the discretion of the doctor.

Our goal is to provide your child with optimum dental service in an efficient and effective manner. Thank you for your cooperation in this matter and we look forward to seeing you at your next appointment.

I, the undersigned, have read, understand and accept the terms of this cancellation policy.

_____ _____

Signature Date

225 East State Highway 121
Suite 150
Coppell, Texas 75019

Phone: 972.315.3355
Fax: 972.315.0017
www.drlindasteele.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ **Patient DOB:** ____/____/____

Patient Address: _____

City _____ **State** _____ **Zip** _____

Date Records Request: _____ **Date Records Released:** _____

I, the undersigned, authorize: _____

- ❑ **To release my medical records from the following doctor and address.**
- ❑ **To obtain my medical records from the following doctor and address.**

_____

_____

_____

Phone: _____

My request for this particular release of medical records includes the following specific records (please include specific time period and/or specific type of record):

_____

_____

Instructions: _____

The facility and its doctors are hereby released and discharged from any liability, and the undersigned will hold the facility and its doctors harmless for complying with this authorization.

Patient Signature: _____ **Date:** ____/____/____

NOTICE TO PERSON OR AGENCY RECEIVING THIS INFORMATION: The information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

FINANCIAL AGREEMENT

Thank you for choosing Dr. Linda Steele as your child's dental care provider. Our primary concern is your child's oral health. We are committed to successful treatment, and to the return and maintenance of your child's good oral health. Please understand that payment of your bill is considered part of that treatment. The following is a statement of our Financial Policy, which we ask that you read and sign prior to treatment.

Assignment of Benefits

I hereby assign benefits to be paid, on my behalf, to the physician who renders service. I understand and agree to be financially responsible for charges not paid for within 90 days by insurance or other third party payer and certify that the information given with regard to insurance coverage correct.

Release of Information

I authorize the physician rendering service to release all or part of my dental records when required for the submission of any insurance claims for payment of services rendered. The dentist, her agent and her employees who render service are hereby released from any and all liability of any nature that may arise from the release of such information.

Dental PPO's

Dr. Linda Steele participates in a limited number of dental plans (PPOs). For families enrolled in these plans, we will bill your insurance directly. Please note that co-pays, deductibles, and fees not covered by your plan are due at the time of service. In some instances, the treatment may be covered under your PPO for a reduced fee. **HOWEVER, IF COVERAGE IS DENIED, THE FEES LISTED ON THE TREATMENT PLAN ARE YOUR RESPONSIBILITY.**

Dental Insurance

We accept most dental insurances and will assist you in maximizing your benefits. **We ask that routine check up visits and treatment balances under $300 be paid at the time of service.** Our office will file your claim electronically on the day of service for direct reimbursement to you from your insurance company. We ask that you, the policy holder, be acquainted with your insurance coverage and benefits. *A case predetermination may be filed with your insurance carrier to help determine the benefits of your individual policy and obtain an ESTIMATE of your portion of the charges due at the time of service. We do not file claims to secondary insurance carriers. Please understand that insurance is a contract between you and your carrier, not our office. If you insurance carrier has not issued payment within 90 days of service, any unpaid professional fees are due and payable in full from you.*

Payment Options

We accept:

- Cash
- Check
- MasterCard
- Discover
- Visa
- American Express
- Payment plans are available through several financing partners.
  *Please note, a 4% service fee will be charged for all debit or credit card charges. Alternately, you may pay with check or cash to avoid the fee.

Financial Policy

- A $50 fee will be assessed for cancellations with less than 24 hour notification at Dr. Steele's discretion.
- A non-refundable $250 fee will be assessed for unattended scheduled hospital appointments.
- A $25 fee is due for each check payment returned by your bank.
- Defaulted payment plans will automatically be turned over to collections after 90 days and a $25 collection fee will be charged.
- Credit balances are kept on your account unless you call or write to request a refund; a check will be mailed at the end of the month the request is made.
- Any collection fees, court costs, or reasonable attorney fees required to collect unpaid accounts are your responsibility.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts the terms as specified above.

Responsible Party:

X _____ X _____

Signature **Date/Time**

_____

Printed Name

LINDA A. STEELE, DDS

Photo Release Authorization for Minor

Authorization to Photograph

I hereby authorize Steele Dental Specialties permission to use photograph(s) of my minor/child as specified below.

I agree that Steele Dental Specialties may use and permit other persons to use the information, negatives or prints prepared as a result for such purposes and in such manner as it may deem appropriate, including but not limited to, medical, educational and scientific journals, newspaper and magazine articles, promotional purposes, movies, or any other media or means of dissemination. In addition, Steele Dental Specialties may use such photograph(s) for presentations on television, our website, social media platforms such as Instagram and Facebook or seminars for the purpose of educating the public about pediatric dentistry. I also authorize and consent to the use of video taping, preparation of drawings and similar illustrative graphic material, and the use of these materials for scientific purposes. I agree that Steele Dental Specialties will be the sole and exclusive owner of such photographs. I understand that any dissemination of the materials described above, which are made public, will be within generally accepted bounds of good taste.

The terms "photograph" or "photographs" as used in the foregoing shall mean motion picture or still photography in any format, as well as videotape, videodisc, or any other mechanical means of recording and reproducing images.

Release of Liability

I hereby waive any right that I may have to inspect or approve the finished products or the advertising copy or printed matter that may be used in connection therewith or the use to which it may be applied. In giving my consent, I hereby release and hold harmless, Steele Dental Specialties, their employees, agents and designees from any and all responsibility or liability. I understand that I, or my minor child, will not receive compensation for the use of this likeness in any form.

Child's Name (Please print)

Parent's Name (please print)

Date

Parent's Signature

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LINDA A. STEELE, DDS

Acknowledgement and Consent of Receipt of Notice of Privacy Practices

All medical facilities are required by Federal and State law to provide each of their patients with a copy of their Notice of Privacy Practices, under the Health Insurance Portability and Accountability Act (HIPAA). This act went into effect April 14, 2003. In addition, we are required by Federal and State law to obtain a signed Acknowledgment from each of our patients indicating they have received the Notice and Consent from our patients to use their health care information for "treatment, payment, and healthcare operations." This act was passed by Congress to protect patients' rights concerning the use of their health care information. In other words, under the new HIPAA regulations, we must take measures to make sure your health care information is not released to parties without your authorization, except for what is necessary to complete our treatment and payment activities. This act will not affect the services you will receive at this office. Thank you for your cooperation.

Purpose of Consent:
By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices:
You have the right to read our Notice of Privacy Practices before you decide whether to sign this Acknowledgment and Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Acknowledgment and Consent.

We reserve the right to change our privacy policies as described in our Notice of Privacy Practices. If we change our privacy policies, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke:
You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we my decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

By my signature below, I acknowledge that I have been provided with a copy of this office's Notice of Privacy Practices. I have had full opportunity to read and consider the contents of your Notice of Privacy Practices and this Consent form. I understand that by signing this Consent form, I am giving my consent to use and disclose my protected health information as necessary to carry out their treatment, payment activities, and health care operations.

INFORMATION SHARING: Please list any individuals we can share your personal information with other than healthcare providers.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature: _____ Date: _____

Print Name:_____

If this Consent is signed by a parent, guardian, or personal representative on behalf of the patient, complete the following:

Representative's Name: _____ **Relationship to Patient:** _____

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