Texas Kids Dental Care
555 North Americas
El Paso, Texas 79907
(915)858-6868

Texas Kids Dental Care of Horizon
14240 Horizon Blvd Ste A
Horizon City, TX 79928
(915)852-5060

Texas Kids Dental Care of Fabens
1018 N Fabens Rd.
Fabens, Texas 79838
(915) 764-0096

Texas Kids Dental Care of Montana
3650 Joe Battle
El Paso, Texas 79938
(915) 855-0948

Patients Information:

Please take a few moments to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name:_____Gender: F___ M___

Race_____ Language(s) Spoken: English Spanish Other_____

Date of Birth: _____ Social Security Number: _____

Address: _____

City:_____State: _____ Zip Code:_____

Responsible Party Information:

Name:_____Gender: F___ M___

Family Status: Married Single Divorced Other

Date of Birth: _____ Social Security Number: _____

Phone Number:_____Cell Phone Number:_____

Employer:_____

Work Number:_____Email: _____

Guardianship of Patient:_____

Emergency Contact:

Name:_____Phone number:_____

Whom may we thank for referring you to our practice? (check all that apply)

- o Dental Office
- o Flyers
- o Cielo Vista Mall
- o Yellow Pages
- o Vista Market
- o Employee
- o Internet
- o Driving by
- o Insurance Plan

- o Relative/Friend:_____
- o Other: _____

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PEDIATRIC DENTAL TREATMENT CONSENT FORM

As healthcare professionals, it is necessary that we obtain your consent for dental/oral treatment of your child. Please read this form carefully and ask any questions that may not be clear, or that you may not understand. **This is only to inform you of what type of services we provide, which varies from child to child according to their needs.**

1. I _____ authorized Dr. Erickson and/or his associates and dental assistant to treat my
(Name of parent/guardian)
child for the following dental or oral surgery procedures, including the use of oral anesthesia, intramuscular anesthesia, oral sedatives or radiographs that may be necessary to provide dental treatment.
2. In general terms the above procedures may include:

Please mark your initials:

A. ____ Dental cleaning, fluoride application and radiographs as necessary.
B. ____ Application of sealants.
C. ____ Restoration of broken teeth or fillings.
D. ____ Treatment of infected teeth or gums.
E. ____ Extractions of 1 or more teeth.
F. ____ Use of "voice control" in order to gain attention of children with negative behavior.
G. ____ Use of physical restraints to properly and securely perform necessary dental procedures.
H. ____ Use of local anesthetics.
I. ____ Use of sedative drugs for the control of nervousness or negative behavior
J. ____ Use of nitrous oxide to help reduce anxiety
K. ____ Use of oral and intramuscular can lead to deep sedation and general anesthesia and the associated risks of these types of anesthesia.
L. ____ IV Sedation or General Anesthesia. The risks of General Anesthesia include, but are not limited to the following: tenderness, bruising, nausea, vomiting, aspiration, swelling, bleeding, infection, numbness, allergic reaction, stroke, heart attack, and death. Some of these complications may require hospitalization. Serious complications are very rare.
M. ____ Due to the difficult nature of managing the behavior of some children or patients, a complete exam is not always possible on the initial visit. I give permission to Dr. Erickson and his associates to perform and dental treatment they deem necessary and appropriate while my child is sedated and cooperative or under general anesthesia.

My child's treatment, alternative methods of treatment, as well as the advantages and disadvantages of each will be explained to me. We will advise you that although the best results are expected, there is no way within reason of anticipating complications. Therefore, it is not possible to guarantee the results or cure of the treatment.
Although the occurrence is remote, it is known that some risks are associated with dental procedures. We are required to mention the following: bleeding, numbness, infection, damage to central nervous system, reduction or loss of function of internal organs and limbs, as well as disfiguring scars. I understand and accept that certain complications may be fatal or require medical intervention.

_____	_____	_____
Parent/Guardian Signature	Date	Witness

TEXAS KIDS DENTAL CARE

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient's Name: _____ Date of Birth:_____

Address: _____

City/Zip_____

Telephone:_____ Work Phone:_____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, 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.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact Person: HIPPA PRIVACY OFFICER

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Fax(915) 858-6878

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Horizon City, TX 79928
(915)852-5060
(915)852-3300

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1018 N Fabens Rd.
Fabens, Texas 79838
(915)764-0096
Fax (915) 764-0012

Texas Kids Dental Care of Montana
3650 Joe Battle
El Paso, Texas 79938
(915)855-0948
(915)921-7190

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact person listed above. 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 may decline to treat you or to continue treating you if you revoke this Consent.

Signature

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature:_____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

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Medical Health History

Patient's Name:_____
Resp. Party's Name:_____
Patient's Address:_____
City:_____ State:_____ Zip Code:_____
Home #:_____ Work #:_____
Cell:_____
Patient's Date of Birth:_____ Sex: F M

Patient's Employer:_____
Resp. Party's Employer:_____
Employer's Address:_____
Patient's Social Security #:_____
Dental Insurance:_____
Insurance ID #:_____
Group #:_____

				Doctor's Notes
1.	Are you under a physician's care? Physician's Name_____ Phone #:_____ Why:_____	Yes	No	<Important
2.	When was your last complete physical exam?_____	Yes	No	
3.	Are you taking any medications or substances?_____ Please list dosage:_____	Yes	No	
4.	Are you allergic to any medication or substances?_____	Yes	No	
5.	Do you have any problems with penicillin, antibiotics, local anesthetics (Novocaine) or other types of medications?_____	Yes	No	
6.	Do you have any other allergies?_____	Yes	No	
7.	Are you sensitive to any metals or latex?_____	Yes	No	
8.	Are you pregnant or suspect you are?_____	Yes	No	
9.	Do you take birth control medications?_____	Yes	No	
10.	Have you ever been treated for heart disease?_____	Yes	No	<Important
11.	Do you have a pacemaker or an artificial heart valve implant?_____	Yes	No	
12.	Are you aware of having a heart murmur?_____	Yes	No	
13.	Do you have high/low blood pressure?_____	Yes	No	
14.	Have you ever had rheumatic fever?_____	Yes	No	
15.	Have you ever had any major illness or surgery?_____	Yes	No	
16.	Have you ever had seizures or convulsions?_____	Yes	No	
17.	Have you ever had radiation treatment, chemotherapy, or any other treatment for cancer?_____	Yes	No	
18.	Do you have soreness, clicking, or popping in their jaw joint?_____	Yes	No	
19.	Do you have any blood disorders, such as anemia, leukemia, hemophilia, etc? _____	Yes	No	
20.	Does the patient have any artificial joints/prosthesis?_____	Yes	No	
21.	Have you ever bled excessively after being cut or injured?_____	Yes	No	
22.	Have you ever received a blood transfusion?_____	Yes	No	
23.	Do you have kidney, stomach, or liver problems?_____	Yes	No	<Important
24.	Are you diabetic?_____	Yes	No	
25.	Do you have asthma?_____	Yes	No	
26.	Are you HIV positive?_____	Yes	No	
27.	Do you have AIDS?_____	Yes	No	
28.	Have you had or do you test positive for Hepatitis?_____	Yes	No	
29.	Do you have or have you had Tuberculosis?_____	Yes	No	
30.	Do you smoke, chew, use snuff or any other forms of tobacco?_____	Yes	No	
31.	Do you consume alcoholic beverages?_____	Yes	No	<Important
32.	Are you currently using any recreational drugs?_____	Yes	No	
33.	Is there anything else we should know about your health that is not covered in this form? _____	Yes	No	

Patient's (Guardian) Signature_____ Date:_____ Reviewed By:_____

**********PLEASE DO NOT SIGN BELOW THIS LINE**********

(1)Any changes? Yes No If yes please list_____

Patient's (Guardian) Signature_____ Date:_____ Reviewed By:_____

(2)Any changes? Yes No If yes please list_____

Patient's (Guardian) Signature_____ Date:_____ Reviewed By:_____

(3)Any changes? Yes No If yes please list_____

Patient's (Guardian) Signature_____ Date:_____ Reviewed By:_____