Lake Country Dental
Ray D Snider DDS & Associates
General, Pediatric, Cosmetic, & Implant Dentistry
Dentistry
for the Entire Family

Welcome to our Practice,

Our pediatric dental practice is dedicated to providing quality care in a setting that children of all ages can enjoy. We are committed to your child's individual needs, both emotional and therapeutic, so that we may provide the highest quality treatment. We accomplish this through efficient teamwork, compassion and patience.

Our staff of professionals are trained and experienced in pediatric dentistry, and we deliver the highest quality care with the very best materials available. You will find that your positive reinforcement and the atmosphere we have created here will give your child the best chance for a good first visit. In order for you to help us with this goal, we would like to offer your child encouragement such as, "The dentist is going to show you many new and fun things to make your teeth sparkle and make your smile bright." Expect your child to enjoy the first visit to our office and chances are he or she will do exactly that. Along with preparing your child, we must be thoroughly prepared for providing the best possible care for your child, so we ask that you please be candid in providing us with complete information concerning your child's dental, medical, and social traits.

We have sent the forms necessary to begin your child's dental records. Once this information is accurately filled out we will be able to effectively communicate with you about your child's dental needs. The forms included are: Patient health history and account information, our office financial policy, and an insurance form for those who have dental insurance. Once you have a chance to go over these forms, call our office if you have any questions.

We recommend an initial visit be scheduled for your child at age 12 months to be followed by enjoyable, familiarization visits which will lead up to a first comprehensive visit prior to age 3. The first visit for patients age 3 and above will consist of x-rays (if indicated), a complete oral and cavity examination to determine if any restorations are needed, and a complete cleaning and fluoride treatment by our hygienist. The hygienist and the dentist will complete the visit by having a consultation with you to relate all of their findings and answer any question you might have.

We hope you share in our belief that regular preventive dental health care is a sound investment in your child's health. We recommend an examination along with a cleaning and fluoride treatment every 6 months. This will be the backbone of preventive care for your child, and it will help us develop a strong, trusting relationship with both of you. We want you to be confident that we will effectively follow through with our best possible care of your child's dental development in order to achieve a healthy and attractive smile.

Lake Country Dental

8461 Boat Club Road
Fort Worth, Texas 76179
871-236-8771 • Fax: 817-236-8249
www.lakecountrydental.com

Name of Minor/Child _____ Soc. Sec.: _____

Sex: F___ M___ Age: _____ Birthday: _____

Home address: _____

City: _____ State: _____ Zip: _____

How Did you hear about our office? _____

Phonebooks: AT & T ___ Family & Friends ___

Transwestern ___ Drive By ___

Yellow Pages ___ Other ___

If you are the parent bringing the child in for dental treatment, you are the Responsible financial party.

Home Phone: _____ Cell: _____

Work Phone: _____ Email: _____

PATIENT INFORMATION

Father's Name: _____ Mother's Name: _____

Address: _____ Address: _____

Cell Phone: _____ Cell Phone: _____

Employer: _____ Employer: _____

Soc. Sec.: _____ Soc. Sec.: _____

Birthdate: _____ Birthdate: _____

INSURANCE INFORMATION

Do you have dental insurance coverage for minor/child? Y N

Plan Name: _____ Group Number _____

Phone Number: _____ Policy Number: _____

Address: _____

DENTAL HISTORY:

Date of last dental visit:_____For what service:_____

Has child complained about any dental problems?_____

How often does your child brush?_____ Floss?_____

Is floride taken in any form?_____Any injuries to mouth, teeth, or head?_____

Any previous unhappy dental visits?_____

Any mouth habits- thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.?_____

MEDICAL HISTORY:

Child's Physician: _____ City/State: _____ Phone: _____

Date of last physical exam: _____

Is minor or child:	Y	N	
Under care of physician	❑	❑	Medication: _____
Receiving any medication	❑	❑	_____
Ever been hospitalized:	❑	❑	Allergies: _____
Ever had surgery			_____

Has child had any history of or difficulty with any of the following? If YES please check:

A.I.D.S.	❑	Bladder	❑	Digestive Issues	❑	Hearing	❑	Mononucleosis	❑
ADD/ADHD	❑	Cancer	❑	Downs Syndrome	❑	Heart	❑	Mumps	❑
Anemia	❑	Cerebral Palsy	❑	Drug/Alcohol	❑	Hepatitis	❑	Rheumatic Fever	❑
Aspergers	❑	Chicken Pox	❑	Epilepsy	❑	Kidneys	❑	Sensory Issues	❑
Asthma	❑	Convulsions	❑	Fainting	❑	Liver	❑	Sinus Problems	❑
Autism	❑	Diabetes	❑	Gagging	❑	Measles	❑	Thyroid Disease	❑
Other	❑							Tuberculosis	❑

Please List _____

In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone: _____

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

In the event any dispute or claim arising from dental treatment or insurance claims cannot be settled by the parties involved, all parties agree to submit said dispute to binding arbitration.

Signature _____

FINANCIAL POLICY and INSURANCE GUIDELINES

Our primary goal is not to allow the cost of treatment to prevent you from benefiting from the quality care your family deserves.

- If you have dental insurance, we will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you and your children achieve the best oral health possible. Ultimately, however, you are responsible for payment regardless of any insurance companies' arbitrary determination. Initial _____

- While we accept all dental insurance plans, we are considered in-network with most PPO dental plans. We are out of network with Cigna Advantage. Delta Dental and some other insurances members: If you receive an insurance check it is to pay your claim at our office. Please bring it in ASAP. Being out of network does not mean you do not receive benefits. We strive to help you make optimal use of your dental insurance and as a courtesy to our patients, we are happy to file your dental insurance claims. Initial _____

- Your insurance policy is an agreement between you and your insurance company; we ask that all patients be directly responsible for all charges. Your estimated co-payment will be due at the time of service, however we cannot guarantee any estimated coverage. You will be expected to pay for services in full if this office is unable to verify your plan information before treatment. Please know that we will do everything possible to see that you receive the full benefits of your policy by electronically filing your claim the day of your appointment. If there are any complications, we will assist you with any information you may need. Initial_____

- If payment for services already rendered has not been paid in full within 6 weeks, either by you or your insurance company, the remaining balance for your treatment is considered due and must be collected from you. Office Delinquent balances over 90 days old will be transferred to a collection agency. The fee accessed for this transfer and administrative expenses is $30.00. Any fees incurred from the collection agency and attorney employed will be passed on to you. Further appointments will not be scheduled until all balances and fees are paid in full. Future appointments will be on a cash only basis. Initial _____

- We accept the following forms of payment: Cash, Check, American Express, Visa and MasterCard. In addition, we offer Care Credit, a patient payment program offering a full range of Deferred Interest and Extended Payment Plans for treatment. Initial _____

- Checks that are returned to our office from your financial institution are subject to a $30.00 returned check fee. This fee covers the processing fees that are charged to our office. Your check will be retained by our office until a full cash payment is received. Initial_____

- Separated or divorced parents of minors, who are responsible for one half of the cost of a child's/children's dental care: The parent who brings the child in to the dental appointment is responsible for paying the co-payment or full fee. Initial _____

- We realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at any time to discuss any concerns you may have. Initial _____

I have read and agree to the Financial Policy and Insurance Guidelines.

Signature of Patient or Responsible Party: _____

Date:_____

PARENTAL POLICY

At Lake Country Dental Pediatrics we want you and your child to have the best dental experience possible. Pleasant visits to the dental office help a child establish trust and confidence that will last a lifetime. Lake Country Dental Pediatrics and Associates have been specially trained to help young, apprehensive children feel good about seeing the dentist and taking care of their teeth. Friendly, compassionate professionals and bright, cheerful office surroundings are all there to help your child feel comfortable and at ease with visiting the dentist. We recommend scheduling younger children in the morning when they are most rested and cooperative. We have open working areas and your child is NEVER left unattended.

If your child is over the age of three, and/or having dental treatment other than a cleaning, we ask that you allow them to accompany our staff, by themselves, through the dental experience. Separation anxiety is not uncommon in children, so please try not to be concerned if your child exhibits negative behavior. This is normal and will soon diminish. **Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own and in an open environment designed for children.**

It is best if you refrain from using words around your child that might cause unnecessary fear, such as needle, pull, drill or hurt. The office makes a practice of using words that convey the same message, but are pleasant and non-frightening to the child. Please do not tell your child the "dentist will not hurt" as this may never have entered his/her mind. Instead, you may wish to assure your child that Lake Country Dental Pediatrics & Associates will be gentle, friendly and fun. *We are very happy that you chose to bring your child to our office and we will continue to make it a delightful experience for everyone.*

Respectfully,
Lake Country Dental Pediatrics & Associates

Acknowledgment of Parental Policy

Signature_____ Date_____

Patient name_____
(Please print)

Lake Country Dental

Ray D. Snider DDS & Associates

Pediatrics, Family Dentistry & Dental Implants

Cancellation Policy

We regret patients must sometimes wait a lengthy time to be seen by one of our dentist. Due to the high demand of appointments and in order to be respectful of the dental needs of all of our patients please be courteous and call our office promptly if you are unable to attend an appointment.
We always have patients on a cancellation list that need care.

If you are unable to keep your scheduled appointment, we require 24 hours notice.

There will be a $35 charge for every appointment missed without proper notification (as mentioned above).

If you miss 2 appointments without proper notification we reserve the right to dismiss the patient from care.

_____ _____

Signature Date

LAKE COUNTRY DENTAL

Patient Name_____

Due to confirmed Cases of COVID-19(CoronaVirus) within the United States, the CDC requires that healthcare facilities conduct a strict screening process on individuals with respiratory symptoms as well as those who have traveled outside of the United States.

Have you had any of the following?

Fever, Cough, Shortness of breath Yes No

Have you been in contact with anyone that has had these symptoms?

Yes No

Have you traveled outside of the country within the last 14 days or been in contact with someone who has?

Yes No

Have you been in contact with anyone who had recent exposure to CoronaVirus? Yes No

If you have answered yes to any of the boxes above we may ask you to reschedule your appointment to prevent the transmission of various diseases and for the safety of other patients and our staff.

Signature:_____ Date:_____

Phone #_____