THERESA M. WHITE, DDS, MS

Southwest Pediatric Dental Associates, PLLC
8101 S. Walker Ave, Suite C
Oklahoma City, Oklahoma 73139
Phone 405.616.7336 Fax 405.616.5756

Welcome!
We are pleased that you have made an appointment for your child at our office, and we look forward to caring for your family. As a pediatric dental office, our routine may be somewhat different than you have experienced in other medical and dental settings. The use of insurance is a privilege; to make our time together most enjoyable, please read and remember the following policies.

Please,

1. **We verify insurance** eligibility for every dental visit. If able, present an insurance card.

2. **Inform us** of changes to address, phone numbers, and insurance.

3. **Be On Time** for your appointment. We have reserved a particular time for you, and we strive to keep you on schedule. Call if you are late, need to reschedule or need to cancel a dental appointment. **We require 24-hour notice when canceling or rescheduling an appointment.** We will contact you within 1-2 business days of the appointment using the phone numbers you provided. **Please confirm the appointment within 24 hours or the patient will lose their reserved spot.**

4. **Remember "No Show Appointments"** occurs when a family does not call before an appointment date to inform our office that the appointment must be rescheduled or cancelled. **After the second (2nd) "No Show Appointment" occurs, this clinic will not be able to reschedule an appointment for that child and all appointments scheduled for the future will be cancelled.** Avoid "No Show Appointments".

AUTHORIZATION:

To the best of my knowledge, the questions on this form have been answered accurately. I understand that the answers I have provided will be used by the dentist to determine the appropriate dental treatment for my child. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners.

I agree to be responsible for payment of all services rendered on behalf of my dependents. Payment is due in full at the time of treatment unless prior arrangements have been approved.

I have read and understand the above policies for the patient listed below:

Child's Name: ______________________________

Signature:______________________________________**Date**______________

Relationship to Patient__________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

Patient Name_____________________________________

I, ____________________________, have received a copy of this office's "Notice of Privacy Practices".

Relationship to Patient _____________________________

Signature____

Date____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)