



WOODLANDS

PEDIATRIC DENTISTRY
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4850 West Panther Creek Dr, Suite 102
The Woodlands, TX 77381
Ph: 281-292-4242

30014 Aldine Westfield Rd, Suite 101
Spring, TX 77386
Ph: 281-393-4044

Let's Get to Know Your Child

Today's date: _____
Child's Name: _____
Birthdate: ____/____/____ Male Female
Preferred Name: _____
Home phone: _____
Address: _____
City: _____ State: _____ Zip code: _____

Who is Accompanying this Child?

Name: _____
Relationship to Patient: _____
Preferred method of contact:
 Phone Email Text
How did you hear about us?
 Referred by Doctor (Name: _____)
 Referred by Family/Friend (Name: _____)
 Other: _____

Parent Information

Mother's Name: _____
Other Guardian: _____
Birthdate: ____/____/____
Cell phone: _____
Work phone: _____
SSN: _____
Occupation: _____
Email: _____
Marital status: Single Married Divorced

Father's Name: _____
Other Guardian: _____
Birthdate: ____/____/____
Cell phone: _____
Work phone: _____
SSN: _____
Occupation: _____
Email: _____
Marital status: Single Married Divorced

Primary Dental Insurance

Policy Owner's Name: _____
Policy Owner's Birthdate: ____/____/____
Insurance Company Name: _____
Policy Owner's Employer: _____
ID #: _____
Group #: _____
Insurance Company Phone #: _____

Secondary Dental Insurance

Policy Owner's Name: _____
Policy Owner's Birthdate: ____/____/____
Insurance Company Name: _____
Policy Owner's Employer: _____
ID #: _____
Group #: _____
Insurance Company Phone #: _____

I certify that my child is covered by the above insurance company and I assign directly to Woodlands Pediatric Dentistry all insurance benefits otherwise payable to me. I understand that I am responsible for payments of services rendered and also responsible for paying any co-payments and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian

Date

Health History

Patient's First Name: _____ Last Name: _____ Birthdate: ____/____/____

Child's Physician: _____ Phone#: _____

Please list all medications with dosage your child is currently taking:

Allergies to: Y/N LATEX Y/N METALS/NICKEL Y/N PLASTIC Others: _____

Has your child ever had any of the following medical issues?

Y/N Vaccinations Up to Date	Y/N Convulsions/Epilepsy	Y/N Sickle Cell Disease/Traits
Y/N Allergies to any drugs	Y/N Diabetes	Y/N Skin Rash/Eczema
Y/N Abnormal Bleeding	Y/N HIV/AIDS (or exposed)	Y/N Special Needs/Disability
Y/N ADD/ADHD	Y/N Hearing impairment	Y/N Tuberculosis
Y/N Asthma	Y/N Heart Disease/Murmur	Y/N Any hospital stays
Y/N Autism/Asperger's/PDD	Y/N Hemophilia/Blood disorders	Y/N Any Operations
Y/N Cancer	Y/N Hepatitis	
Y/N Congenital Heart Defect	Y/N Kidney/Liver Conditions	

Please discuss any hospital stays or surgeries: _____

Please discuss any serious medical conditions the child has/had: _____

Dental History

Is this your child's first visit to the dentist? _____

If not, when was the last dental visit? _____

Where? _____

Chief purpose of this dental visit: _____

Is your child in pain now? _____

Has your child had previous dental treatment? _____

Has your child had any unfavorable dental/medical experience? _____

If yes, please explain: _____

Has your child had any history of:

Y/N / Current Thumb/Finger sucking

Y/N / Current Prolonged breast or bottle feeding

Y/N / Current Pacifier past age 2

Y/N / Current Bed wetting

Y/N / Current Snoring

Y/N / Current Pain/Tenderness jaw joint (TMJ/TMD)

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform the 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.

Signature of Parent or Guardian _____

Date _____

Relationship to patient _____

Woodlands Pediatric Dentistry

Scott A. Andersen, DDS
Tab R. Imdacha, DDS, MSD

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Patient /Parent name _____
Dependents: _____

Patient Treatment and Financial Policy

Thank you for choosing our office as your dental healthcare provider. We are committed to providing you with the highest quality lifetime dental care, so that you may attain optimum oral health.

The following is a statement of our Financial Policy, which we require that you read, agree to and sign prior to any treatment.

Please Note : Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express and CareCredit. Outside financing is available upon request and approval.

Please note: Additional fees will be applied for returned checks. All account balances over 90 days are subject to a \$15.00 late fee.

Do you have insurance?

- As a courtesy to you, we will help you process all of your dental insurance claims. Please understand that we will provide an insurance estimate to you; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums which are your responsibility. Please contact your insurance company for a detail of your benefits. Your insurance company and your plan benefits ultimately determine the amount paid. We will do all we can to ensure your estimate is as accurate as possible. Your estimated insurance benefit may differ due to a number of reasons, specifically related to your plan.
- All charges you incur are your responsibility, regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office. I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

- We ask that you pay the deductible, co-payment and co-insurance, which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa, Discover, American Express and CareCredit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.

Minors accompanied by the parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment are responsible for full payment at time of service. **Unaccompanied Minors:** The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or non-emergency treatment may be denied.

Missed Appointment (s) and Cancellations:

Our goal is to provide treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require at least a 24 hour notice for cancellations or for re-scheduling your appointments. We understand that unforeseen circumstances may arise, which may result in canceling or missing your appointment. A charge may be assessed for multiple missed, short notice or cancelled appointments.

Consent:

I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for my dependents is mine, due and payable at the time services are rendered.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile/cellular or similar devices for any lawful purpose.

Patient /Parent name printed _____

Patient /Parent signature _____ Date _____

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Woodlands Pediatric Dentistry
4850 W. Panther Creek Dr. Ste. 102
The Woodlands, Texas 77381
281-292-4242

Tab R. Imdacha DDS,MSD
Woodlands Pediatric Dentistry
30014 Aldine Westfield Rd. Ste 101
Spring, Texas 77386
281-393-4044

Authorization for Disclosure of Protected Information

Under the Health and Human Privacy Act, we are required to obtain your authorization for your child to participate in selected media sites that relate to our office.

When permission is received from the parent/guardian, you are giving Woodlands Pediatric Dentistry authorization to use your child/child's picture or video on the social media sites listed in this document.

I _____ do _____ do not _____ authorize the use of my child/children's picture or video on the following social media sites enclosed in this disclosure. This authorization will begin on _____ and end when my child is no longer a patient of this office or when I deem necessary to revoke this authorization.

Please list the name(s) of your children below:

We use Facebook, Twitter, and Instagram to promote our kid friendly environment. We will never use your child/children's info randomly. We will always inform you prior to using any personal info.

Like us on facebook. Follow us on twitter @DrScottAndersen. Look for pictures on Instagram @twkidsdentist.

Woodlands Pediatric Dentistry

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT
CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

OUR LEGAL DUTY

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect February 16, 2026, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. We will post a copy of our Notice in our office and on our website www.twkidsdentist.com. The effective date of the Notice is provided above.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use or disclose your health information to another dentist or health care provider providing treatment to you, or if we refer you to another health care provider.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.

Health Care Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

To Your Family, Friends, and Other Persons Involved in Your Care: We may share with a family member, friend, or other person identified by you, your health information that is directly related to that person's involvement in your care or payment for your care, or to notify such individuals of your location or general condition, but only if you agree that we may do so, or, based on our professional judgment, we determine that you would not object to the disclosure. We will also use our professional judgment and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state workers' compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations; in certain situations if you agree or object; as required by law; to contact you; and to send you health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request to us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and health care operations, and certain other activities for the last six years, but not before October 08, 2018. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 30014 Aldine Westfield Rd, Suite 101, Spring, TX 77386.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 30014 Aldine Westfield Rd, Suite 101, Spring, TX 77386. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the Privacy Officer, 30014 Aldine Westfield Rd, Suite 101, Spring, TX 77386.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 30014 Aldine Westfield Rd, Suite 101, Spring, TX 77386. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer
30014 Aldine Westfield Rd Suite 101
Spring, TX 77386
Telephone: 281-393-4044

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

Please Print Child / Children's Names

{Please Print Name}

{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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)



WOODLANDS

PEDIATRIC DENTISTRY

Scott A Andersen DDS • Tab R Imdacha DDS MSD

Consent for Dental Care of Minors in Absence of Parent/Legal Guardian

This consent form allows the person you chose to seek dental treatment and sign consent for your child when you are unable to come with the child.

- The person you name must be 18 years of age or older.
- Please use a separate form for each child.
- **Payment must be provided at time of appointment or in advance.**

I, (parent/legal guardian) _____, give permission to

(person's name) _____, to accompany (child's name)

_____ and: (check **one**)

- I give permission for this person to seek dental treatment for my child **if the attempt to contact me is unsuccessful**. This permission includes exam, xrays, cleaning, fluoride treatment, and any other dental treatment deemed necessary by Dr. Tab Imdacha or Dr. Scott Andersen and their team. This consent shall remain in effect until cancelled by me in writing.
- I give permission for this person to seek dental treatment for my child **without having to contact me**. This permission includes exam, xrays, cleaning, fluoride treatment, and any other dental treatment deemed necessary by Dr. Tab Imdacha or Dr. Scott Andersen and their team. This consent shall remain in effect until cancelled by me in writing.
- My child is of legal driving age and may be unaccompanied to dental appointments. I give consent for any and all dental treatment that has been previously discussed.

Parent/Guardian Signature: _____ Date: _____

Phone Number: (_____) _____ - _____