

# NEW PATIENT FORM

## PATIENT INFORMATION

Patient's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_  M  F Age: \_\_\_\_\_

Names of Siblings: \_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

\_\_\_\_\_ Age: \_\_\_\_\_

Is your child adopted?  Yes  No

Who has legal guardianship of your child?

\_\_\_\_\_

### RESPONSIBLE PARTY NUMBER #1

Mother  Stepmother  Legal Guardian

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_

Cell# \_\_\_\_\_

Home# \_\_\_\_\_

Email \_\_\_\_\_

Is this the child's primary address?  Yes  No

### RESPONSIBLE PARTY NUMBER #2

Mother  Stepmother  Legal Guardian

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_

Cell# \_\_\_\_\_

Home# \_\_\_\_\_

Email \_\_\_\_\_

Is this the child's primary address?  Yes  No

## INSURANCE INFORMATION

Do you have coverage for your child?  Yes  No

Primary Ins. Company \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_

ID#/SS \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Phone \_\_\_\_\_

Secondary Ins. Company \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_

ID#/SS \_\_\_\_\_ Group # \_\_\_\_\_

Ins. Phone \_\_\_\_\_

## OFFICE POLICIES

**A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY YOUR CHILD ON THIS FIRST VISIT.**

**RESPONSIBLE PARTY POLICY:** Because a large percent of the population involves a divorce situation, it is our policy to collect from the parent who brings the child in for dental services.

**OFFICE POLICIES:** Unless appointments are canceled at least 24 hours in advance, our policy is to charge \$75 for missed appointments. We do attempt to confirm appointments, but do so as a courtesy. The Parent/Guardian is responsible for any scheduled appointments for the child.

I acknowledge that I have read and agree to the above policies:

Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## PLEASE READ & INITIAL

I hereby give the dentist permission to complete an oral exam, Radiographs (X-rays) and photographs for diagnostic purposes. I understand this visit will include a cleaning and fluoride treatment as well. \_\_\_\_\_

Payment is due in full for each appointment as services are rendered. If you have dental insurance, we collect your ESTIMATED portion. Dental insurance usually covers only part of the fees for services based on your specific dental benefit underwriting. We do our best to provide you with an estimate accordingly. \_\_\_\_\_

Please understand that the contract for dental insurance is between you and your insurance company and not our practice. Any disputes of coverage need to be handled through the insurance company directly by you and you accept personal financial responsibility for services provided. \_\_\_\_\_

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Ramona Pediatric Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

As a courtesy to you, we will complete and file insurance forms relative to dental services and will do our best to collect all fees due from your insurance carrier. Be aware that some insurances (like Delta Dental) pay the patient directly; in that case we will collect all payment from you up front. \_\_\_\_\_

I realize that failure to keep this account current may result in the dentist being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. \_\_\_\_\_

I authorize the staff at Ramona Pediatric Dentistry to release my child's / my dental records and x-rays to another healthcare provider to facilitate their care. \_\_\_\_\_

Your signature here authorizes assignment of benefits to us so we can submit claims.

## HEALTH HISTORY

Child's Name \_\_\_\_\_  M  F

Grade \_\_\_\_\_ Age \_\_\_\_\_

Child's Hobbies/Interests \_\_\_\_\_

Child's Pediatrician \_\_\_\_\_

Last Physical \_\_\_\_\_

Is your child under a physician's care now?  Y  N

If yes, reason \_\_\_\_\_

Immunizations up to date?  Y  N

Current Medications?  Y  N

If yes, please list \_\_\_\_\_

Allergic to Medication?  Y  N

If yes, please list \_\_\_\_\_

Child have allergic reaction to any of the following?

Latex  Other

If Other, please list \_\_\_\_\_

Has your child ever been a patient in a hospital?  Y  N

If yes, please explain: \_\_\_\_\_

Has your child ever been seen in an emergency room for

ANY reason?  Y  N

If yes, please explain: \_\_\_\_\_

Is your child required to take an antibiotic/pre-med before a dental visit?  
 Yes  No

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

**Please check Yes or No for each box**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> ADHD/ADD             | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Premature Birth       |
| <input type="checkbox"/> Allergies (seasonal) | <input type="checkbox"/> Down's Syndrome      | <input type="checkbox"/> Radiation Treatment   |
| <input type="checkbox"/> Adrenal Disorder     | <input type="checkbox"/> Ear Aches/Infections | <input type="checkbox"/> Recreational Drug Use |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Eating Disorder      | <input type="checkbox"/> Rheumatic Fever       |
| <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Seizures              |
| <input type="checkbox"/> Autism               | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Sinus Problems        |
| <input type="checkbox"/> Bladder              | <input type="checkbox"/> Hearing              | <input type="checkbox"/> Skin Disorder         |
| <input type="checkbox"/> Bleeding             | <input type="checkbox"/> Heart                | <input type="checkbox"/> Smoking/Vaping        |
| <input type="checkbox"/> Blood Disorder       | <input type="checkbox"/> Hepatitis            | <input type="checkbox"/> Surgery (history)     |
| <input type="checkbox"/> Blood Pressure       | <input type="checkbox"/> HIV/AIDS             | <input type="checkbox"/> Speech Problems       |
| <input type="checkbox"/> Blood Transfusion    | <input type="checkbox"/> Immune System        | <input type="checkbox"/> Thyroid Disease       |
| <input type="checkbox"/> Bone Disorder        | <input type="checkbox"/> Intestine/Stomach    | <input type="checkbox"/> Tumors                |
| <input type="checkbox"/> Brain Injury         | <input type="checkbox"/> Kidney               | <input type="checkbox"/> Tuberculosis          |
| <input type="checkbox"/> Bruising             | <input type="checkbox"/> Learning Difficulty  | <input type="checkbox"/> Asthma                |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> Liver Disease        | Last Asthma Attack:<br>_____                   |
| <input type="checkbox"/> Cold Sores           | <input type="checkbox"/> Lung Disorder        | <input type="checkbox"/> Other:<br>_____       |
| <input type="checkbox"/> Chemotherapy         | <input type="checkbox"/> Physical Disability  |  |
| <input type="checkbox"/> Depression           | <input type="checkbox"/> Pregnancy            |  |

If yes to any, please explain: \_\_\_\_\_

\_\_\_\_\_

## DENTAL HISTORY

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

If no, previous dentist \_\_\_\_\_

Date of last visit \_\_\_\_\_

How was his/her experience? \_\_\_\_\_

Child's attitude towards the dentist or dental care  
\_\_\_\_\_

Any injuries to teeth or mouth?  Y  N

Does your child have any of the following habits?

Thumb/Finger  Pacifier  Nail Biting  Lip Sucking

Mouth-breathing  Snoring  Teeth Grinding

Nursing  Bottle Feeding

Is your water fluoridated?  Y  N

Does your child take fluoride supplements?  Y  N

Does your child use fluoridated toothpaste?  Y  N

How often does your child brush his/her teeth? \_\_\_\_\_x/day

How often does your child floss? \_\_\_\_\_x/day

Reason for your child's visit today  
\_\_\_\_\_

## DIET HISTORY

Did you or do you breastfeed your child?  Y  N

What age did you discontinue breastfeeding? \_\_\_\_\_

What foods does your child like for a snack? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What does your child drink on a daily basis? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any changes in health and/or medication.

Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## INSURANCE AND FINANCIAL POLICY

At Ramona Pediatric Dentistry, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation.

\_\_\_\_\_ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

\_\_\_\_\_ We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

\_\_\_\_\_ We accept cash, personal checks, debit card, Master Card, Visa, Discover Card, and American Express. If you are in need of an extended finance option, we also work with CareCredit, who offers 3, 6, or 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Our office staff would be happy to provide you with more detailed information on this plan if you are interested. Outstanding balances older than 90 days are subject to finance charges at the rate of 1.5% monthly. Returned checks are subject to a \$25 administrative fee in addition to any outstanding amount. In the unfortunate event that your account needs to be forwarded to a collection agency you will be responsible for your outstanding balance, accrued interest, and any collection agency charges that may be imposed.

\_\_\_\_\_ Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. We cannot render services on the assumption the charges will be paid for by an insurance company. All charges on all accounts for which you serve as the guarantor are your responsibility from the date the services are rendered. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

\_\_\_\_\_ You may direct the insurance company to pay their share of the cost directly to our office (Assignment of Benefits). Often, we do not receive these payments until two to three months after being submitted for payment therefore you will be required to pay your estimated share at the time treatment is rendered. Upon receipt of the insurance payment we will reconcile your account and bill or refund any difference. In the event that your insurance company does not pay within 90 days of rendering treatment, please understand that the guarantor of your account is responsible for this outstanding balance.

I agree with the above conditions.

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient/Parent Signature: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE  
OF PRIVACY PRACTICES AND CALIFORNIA  
DENTAL MATERIALS FACT SHEET**

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\*\* You May Refuse To Sign This Acknowledgement \*\*

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

Please Print Name \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

I, \_\_\_\_\_, have received a copy of the *California Dental Materials Fact Sheet*.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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**For Office Use Only**

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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)
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