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

☐ Father ☐ Stepfather ☐ 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. _____

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.

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 _____

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

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

Last Asthma Attack: _____

☐ Other: _____

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

** 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 _____

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 specifiy)

_____