Tooth Booth Pediatric Dentistry

10165 Foothill Blvd. Suite #4 Rancho Cucamonga, CA 91730 Phone: (909) 945-CARE (2273)

Demographic Information

Patient Name_____ Patient DOB _____ Age _____ Gender _____ Date _____

Patient's School_____ Phone# _____ Grade _____

Do you have other children that come to Tooth Booth Pediatric Dentistry? □ Yes □ No

If yes, Name(s) and age(s) of other children in the family _____

Parent/Guardian 1: Relationship with Patient □ Mother □ Father □ Other _____

Full Name _____ SSN _____ DOB _____

Address _____ City _____ Zip _____

Phone Number (_____) _____ Employer _____ E-mail _____

Parent/Guardian 2: Relationship with Patient □ Mother □ Father □ Other _____

Full Name _____ SSN _____ DOB _____

Address _____ City _____ Zip _____

Phone Number (_____) _____ Employer _____ E-mail _____

Person(s) financially responsible for payment of patient's account _____ (not the insurance company)

Who has legal custody of patient? □ Mother □ Father □ Both Mother & Father □ Other _____

Is there a court order in place? □ Yes[1] □ No [1]If yes, please provide a copy of the court order.

Who does the patient reside/live with? □ Mother □ Father □ Both Mother & Father □ Other _____ (Name/Relationship)

Address of where the patient resides/lives:_____ City _____ Zip _____

How did you hear about our office? _____

Health History

□ Yes □ No Is your child in good health?

Name of Child's Physician_____Phone (_____) _____

Date of last physical exam_____/_____/_____

□ Yes □ No Has your child had a health problem? _____

□ Yes □ No Has your child ever been hospitalized? Please give reason(s) and date(s) _____

□ Yes □ No Has your child had any surgeries in the past? Please give type of surgeries, give reason(s) and date(s). (Heart surgery, placement of pins or screws, tonsil surgery, kidney surgery, etc.) _____

□ Yes □ No Does your child have any diagnosed or undiagnosed emotional and/or behavioral condition(s)/disorder(s)? (i.e., ADD, ADHD, ASD, etc.) Please list condition(s) and symptom(s). _____

□ Yes □ No Is your child allergic to any food(s) or medication(s)? (i.e., latex, peanuts, amoxicillin, etc.) _____

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Health History (cont'd)

□ Yes □ No Is your child currently taking any medication(s)? Please give medication(s) and reason(s) _____

_____

□ Yes □ No Were there any problems at birth? _____

_____

Please check if your child **has been** treated for any of the following: □ Yes □ No

□ Heart Disease	□ Bleeding/transfusions	□ Asthma	□ Blood Dyscrasia
□ Liver/GI Disease	□ Anemia	□ Diabetes	□ AIDS
□ Kidney Disease	□ Rheumatic Fever	□ Hepatitis	□ Mental Delays
□ Speech/Hearing	□ Seizures	□ Cleft Lip/Palate	□ Physical Delays
□ Cerebral Palsy	□ Congenital Birth Defects	□ Personality/Social	□ Heart Murmurs
□ Cancer/Tumors	□ Recurrent Headaches	□ Frequent Infections	□ Other Problems

Please elaborate on any items checked (i.e., pre-medication for heart condition, inhaler for asthma, iron for anemia, etc): _____

_____

_____

Do you consider your child to be

□ Advanced in the learning process

□ Progresses Normally

□ Slow in the learning process

□ Not applicable

Was your child □ Breast Fed □ Bottle Fed □ Both Breast & Bottle Fed At what age was it stopped? _____

Dental History

□ Yes □ No Has your child ever been to the dentist? Please give dentist(s) and date(s) _____

_____

□ Yes □ No Has your child experienced any unfavorable reaction(s) from previous dental care? Please Explain. _____

_____

□ Yes □ No Does your child suck a finger, thumb, or pacifier?

□ Yes □ No Does your child have pain with chewing, yawning, or wide opening?

□ Yes □ No Does your child's jaw make noise and is pain associated with the sounds?

Please check if child is having problems with any of the following: □ Yes □ No

□ Cavities	□ Toothache	□ Teeth Sensitivity
□ Trauma	□ Gum Infections	□ Color of Teeth
□ Orthodontics	□ Jaw Sounds	□ Other

Comments _____

_____ _____

Signature of Parent/Guardian **Date**

_____ _____

Signature of Dentist **Date**

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FINANCIAL POLICY

Thank you for selecting our office as your child's pediatric dental provider. The following is a statement of our financial policy which we ask that you read, understand, and sign prior to any treatment.

We are committed to providing your child with the best possible dental care and we are happy to discuss our professional fees with you at any time during our normal business hours. Your clear understanding of our financial policy is important to our professional relationship. Please do not hesitate to ask if you have any questions or concerns about our fees, our financial policy, or your responsibility. Payment is required at each appointment before service is rendered and can be made by cash, MasterCard, or Visa; *No personal or business checks will be accepted*. Please be aware that the parent/guardian accompanying the child to our office is legally responsible for payments on all charges. We cannot send statements to other addresses or adults who are not present.

DENTAL INSURANCE INFORMATION

As a courtesy to you, our patients, we will file your dental insurance claim for you. We also, as a courtesy to you, will accept assignment of benefits. Once we have verified your insurance benefits, we will file the claims for you. We estimate what we think it will be and we ask that you pay the remaining balance at the time services are rendered. If there is still a balance after an insurance payment has been issued, you will be billed the remaining portion. Although we normally verify insurance eligibility prior to your visit, payment for your visit is subject to review by your insurance company. You, the parent/guardian, are responsible for your entire account balance. If, for some reason, your insurance company does not pay on your claim, you are expected to pay it in full within 30 days of the date of treatment. If your insurance company becomes unduly difficult to deal with, we will ask that you proceed with whatever measures you deem appropriate to collect on your claim.

Payment plans will be offered only through Care Credit. Please visit www.CareCredit.com for more information. You may also contact our office for more information.

Patient's Name _____

Subscriber Name _____

Subscriber Date of Birth _____

Subscriber SS# _____

Subscriber Employer _____

Insurance Company Name _____

Insurance Company Phone Number _____

By signing below, I hereby acknowledge that:

I authorize the release of any information concerning my child's health care, advice and treatment provided for the purposes of evaluating and administering claims for insurance benefits.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

I understand that I am financially responsible for payments in full for all accounts.

Print Name of Parent/Guardian:_____ **Signature of Parent/Guardian**: _____ **Date**: _____

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Verification of Other Coverage from Participant

Plan Participant must provide the following information regarding health and dental coverage, which must be verified annually to prevent claim denies and processing delays. Parent/Guardian is financially responsible for balances created from denied claims/unpaid claims due to incomplete or noncurrent Plan Participant Questionnaire required by the health and dental plan.

Is anyone in the family (your spouse/partner, any of your dependents, or yourself) covered by another health insurance or health benefit plan, or any federal or state government program, including Medicare?

_____No. If no other coverage, please sign and date below.

_____No. If previous coverage terminated, provide termination date: ____/____/____. Please sign and date below.

_____Yes. If other coverage, please provide the following information for the primary person (Plan Member) covered by the other plan.

Name of Plan Member:_____ DOB:_____

Plan Member SSN/Plan ID#:_____ Local Union:_____

Plan Effective date:_____

Is Member an Active Employee? □ Yes □ No If yes, hire date: ____/____/____

Is Member a Retired Employee? □ Yes □ No If yes, hire date: ____/____/____

Name of employer or organization providing other coverage:_____

Insurance Company Name:_____

Insurance Company Address:_____ City _____ Zip _____

Insurance Company Phone#:_____

Insurance Plan Group#:_____

Insurance Plan Policy#:_____

Plan Type: □ Group □ Individual

Coverage Type: □ Medical □ Dental

Does this Plan include dependent coverage? □ Yes □ No

If yes, list dependents covered:_____

_____

I hereby certify that the foregoing statements are to the best of my knowledge and belief true, correct and complete. If this statement changes in any way, I agree to contact your office immediately.

Parent/Guardian/Plan Member Signature_____ Date:_____

Any person making a willful misrepresentation in completing this form shall be liable to the Plan for any loss to the Plan resulting from such misrepresentation.

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REQUEST AND CONSENT FOR PEDIATRIC DENTAL TREATMENT

Please read this form *carefully*!

Please ask if you have any questions or concerns. We will be pleased to explain.

1. I request and authorize the treatment and procedures outlined on the PLAN OF CARE for:

   Patient Name _____

   Date of Initial Visit _____/_____/_____

2. I further request and authorize the cleaning, fluoride treatment, dental x-rays and the use of anesthetics as may be considered necessary to treat the patient's dental problem(s).
3. I have had explained to me by the dentist and his associates, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.
4. The usual and most frequent risks or complications occurring from this planned treatment and procedures also have been explained to me. These risks include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.
5. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's PLAN OF CARE and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in-office.
6. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
7. I understand that should the patient become uncooperative during dental procedures with movement of head, arms and/or legs, dental treatment cannot be ***safely*** provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements.
8. I further understand that should the patient become uncooperative during dental procedures with *excessive* body movements, the patient may need to be wrapped in a "hug blanket" or "papoose board" to prevent injury and enable the dentist to ***safely*** perform the necessary treatment.
9. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.
10. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the PLAN OF CARE.
11. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
12. I confirm that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

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Consent for Dental Treatment

I request and authorize the dentist to examine, clean, and provide dental treatment on my child's teeth. I further re- quest and authorize the taking of dental x-rays as may be considered necessary by the dentist to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The dentist will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

_____

Signature of Person Consenting to Treatment **Date**

_____

Signature of Dentist **Date**

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I have been presented with a copy of the "Notice of Privacy Practices," detailing how my child's health information may be used and disclosed as permitted by federal and state law. I understand the contents of this notice.

I understand that I have the right to request restrictions concerning the use of any information. I requested the following restrictions: _____

Print Name of Parent/Guardian:_____ **Signature of Parent/Guardian:** _____ **Date:** _____

INTERNAL USE ONLY

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on_____at_____am / pm

Date **Time**

By _____

Name and Title

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operations (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, or conducting and arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required by Law: Public Health issues as required by law, Communicable Diseases, Health Oversight, Abuse or Neglect, FDA requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation; Research: Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted Uses and Disclosures Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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HIPAA Notice of Privacy Practices (Cont'd)

Your Rights
The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law and prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have a right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint**. This notice was published and becomes effective on/or before **April 14, 2003**.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Your signature below is an acknowledgement that you have received this Notice of our Privacy Practices.

Print Name:_____ **Signature**:_____ **Date**:_____

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Cancellation & Missed Appointment Policy

Our goal at Tooth Booth Pediatric Dentistry is to provide you and your child with convenient accessible, high- quality dental care. In order for our practice to ensure convenience and accessibility to all of our patients, it is important that patients arrive on time for all scheduled appointments or cancel the appointment 24 hours in advance. Late arrivals, missed appointments, or canceled appointments without 24 hours advanced notice will be subject to a **$25 fee per patient**. This policy allows our practice to make better use of our available appointments for other patients in need of dental care.

Cancellation of an Appointment

You may cancel your scheduled appointment by emailing our practice anytime at toothbooth4kids@gmail.com or calling the office during regular business hours. This should be 24 hours in advance of the scheduled appointment date and time. Repeated missed appointments may result in discharge from the practice.

Missed Appointment Policy

A "missed appointment" is an occurrence where someone does not show up for an appointment and does not cancel the appointment in advance of the scheduled date and time. If you are more than 15 minutes late this is also considered a missed appointment as it does exceed 50% of the scheduled appointment time. If you do not show up for your appointment, arrive more than 15 minutes late, or do not cancel the appointment 24 hours in advance, we will document this as a "missed appointment."

Fees for Appointments – Financial Agreement

Failure to arrive on time, reschedule, or cancel the appointment within 24 hours of the scheduled appointment time is considered a missed appointment and will result in a fee of **$25 per patient**. This fee is not covered by insurance and will not be submitted to insurance. It will be billed directly to the patient and it must be paid prior to scheduling the next appointment. The $25 fee is not a one-time fee and will be charged per patient for every missed appointment. Repeated missed appointments may result in discharge from the practice.

As a courtesy to our patients we try to confirm all appointments via phone/email; however, it is ultimately the patient's responsibility to keep their appointment. Appointments are in high demand and your early cancellation will give another patient the opportunity to be seen.

Thank you for your understanding and we appreciate your cooperation in advance.

Patient Name **Patient Date of Birth**

Parent/Guardian Name & Signature **Date**