CHILDREN'S DENTISTRY OF RANCHO CUCAMONGA

Welcome to our practice!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for a lifetime.

Child's Name _____
Nickname _____ Sex _____
Birth Date _____
Address _____
City _____ State _____
Zip Code _____ Phone _____
Child lives with _____

Mother Stepmother Guardian

Name _____
Home Phone _____
Work Phone _____
Address _____
City _____ State _____
SSN _____ DOB _____
Employer _____

Father Stepfather Guardian

Name _____
Home Phone _____
Work Phone _____
Address _____
City _____ State _____
SSN _____ DOB _____
Employer _____

Parent/Guardian Marital Status

Single Married Separated
Divorced Widowed

Primary Dental Insurance

Insured's Name _____
Relationship _____
DOB_____ SSN _____
Employer _____
Insurance Co. _____
Phone _____
Group # _____
Address _____

Secondary Dental Insurance

Insured's Name _____
DOB _____ SSN _____
Employer _____
Insurance Co. _____
Phone _____
Group # _____
Address _____

Who makes this child's appointments?

(Responsible party)

Name _____
Home Phone _____
Cell Phone _____
Work Phone _____
E-mail Address _____

Who may we thank for your referral? _____

Signature _____ Date _____

HEALTH HISTORY

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Child's Name _____
Date of Birth _____
Today's Date _____

Dental History

How often does your child brush? _____
How often does your child floss? _____
Is this your child's first visit to the dentist? _____
Date of last dental visit_____
Previous dentist_____
Has your child had any difficulty with previous visits? □ yes □ no
Comments_____
Child's physician_____
Address_____
Phone number_____

Is your child's water fluoridated?	□ yes □ no □ don't know
Does your child take fluoride supplements?	□ yes □ no □ don't know
Does your child have any of the following habits?	
Suck thumb/finger	□ yes □ no
Suck/bite lip	□ yes □ no
Bite/chew nails	□ yes □ no
Pacifier	□ yes □ no
Chew hard objects	□ yes □ no
Grind teeth	□ yes □ no
Clench jaw	□ yes □ no

Please complete other side

Medical History

Has your child ever had any of the following?

ADD/ADHD	□ yes □ no	Diabetes	□ yes □ no
Abnormal Bleeding	□ yes □ no	Down Syndrome	□ yes □ no
Allergies/Hay Fever	□ yes □ no	Handicaps/Disabilities	□ yes □ no
Asthma	□ yes □ no	Heart Murmur	□ yes □ no
Autism	□ yes □ no	Type _____	
Cancer/Hepatitis	□ yes □ no	Hemophilia/Bleeding Disorder	□ yes □ no
Cerebral Palsy	□ yes □ no	HIV/AIDS	□ yes □ no
Congenital Heart Defect	□ yes □ no	Rheumatic Fever	□ yes □ no
Convulsions/Epilepsy	□ yes □ no	Tuberculosis	□ yes □ no
Sickle Cell Anemia or Trait	□ yes □ no		

Has your child ever taken Fen-Phen/Redux? □ yes □ no

Persistent cough or throat clearing not associated with known illness? □ yes □ no
(Lasting more than three weeks)

Is your child taking any medications? □ yes □ no

Please list_____

Is your child allergic to any foods or medications? □ yes □ no

Please list

_____

Is your child allergic to latex? □ yes □ no

Is your child allergic to Local Anesthetic (Novocain) □ yes □ no

Does your child have any rods, pins, screws or implants? □ yes □ no

Please explain any medical problems your child may have _____

_____

Is there any information about your child we should be aware of?_____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other dental practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group the insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf of my dependents. I understand there is a twenty-five (25) dollar broken appointment fee per half hour my child is scheduled without twenty-four (24) hour notice. Chronic failed appointments will be subject to dismissal from our office.

Signature _____ Date _____

(Parent or Guardian)

Reviewed with parent _____ Date_____

Patient Attendance Policy

Children's Dentistry of Rancho Cucamonga
9469 Haven Avenue, Suite #100 Rancho Cucamonga, CA 91730

Please be aware of the following attendance policy that will be effective immediately. In order for us to provide the best service to our patients it is important that every patient attend their appointments as scheduled. Poor attendance will no longer be acceptable and we will sadly have to dismiss those who continue to be unreliable.

OUR EXPECTATIONS

If you are unable to make your appointment as scheduled we will expect you to inform us **AT LEAST 24 HOURS BEFORE** your appointment. We understand that emergencies and unexpected changes will occur at the last minute; therefore, we have provided some leniency in our policy.

"Missed Appointment"

It will be considered a "missed appointment" if you miss your appointment without notifying us in advance. **Two "missed appointments" within a 12 month period will result in dismissal from our office.**

"Less than 24 hour cancellation"

If you call to cancel your appointment less than 24 hours before your appointment it will be considered a "Less than 24 hour cancellation". **Three "Less than 24 hour cancellation" in any 12 month period will result in dismissal from our office.**

Fee for "missed appointment" and "less than 24 hour cancellation"

A $25.00 fee will be charged for each "missed appointment" and "Less than 24 hour cancellation".

I have read and understand the policies listed above.

_____ _____

Parent/Guardian signature Date

Children's Dentistry of Rancho Cucamonga
Our Financial Policy

Non-insured patients are expected to pay in full with cash, check, credit card or CareCredit the day service is rendered.

As a courtesy for patients who are covered by insurance we will submit an insurance claim on your behalf. We accept assignment of benefits. This means you must sign the portions of your insurance that "assigns" payment to our office. Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and portion of charges the day services are rendered. All estimates are based on information provided to us by your insurance company and are not a guarantee of payment. Only after a claim is submitted and reviewed by your insurance company can final payment be determined. We are a non-preferred provider for most PPO insurance plans and this may also affect your out of pocket cost. If you are unsure if we are a provider please feel free to ask the receptionist.

Sometimes our dentists may recommend services that are not covered or exceed the frequency limits of an insurance plan. Our dentists do not follow insurance dictates in diagnosis or recommendations. When services are not covered by insurance the responsibility for payment is yours. It is **your responsibility** to know which services are covered or not covered. If you do not want a specific procedure done it is your responsibility to make an assistant or dentist aware of this decision. We do not check your benefits at each visit. Should there be any changes with eligibility, coverage, frequencies, deductibles or should you change insurance plans it is your responsibility to update the receptionist.

We will estimate as closely as possible to your coverage but until we actually receive your processed claim **it is just an estimate**. We will assist you in dealing with your insurance company but ultimate responsibility lies with you. After forty-five days any remaining balances not received from your insurance company is due in full from you. All unpaid balances over thirty days are subject to a finance charge of 18.00% as well as a five dollar late charge. Insufficient checks are subject to a $25.00 bounced check fee as well as the balance. Delinquent balances will be subject to a collection charge. Please feel free to ask the receptionist if you have questions.

I have read the above and understand it.

_____ _____

Parent or Guardian signature Date

CHILDREN'S DENTISTRY OF RANCHO CUCAMONGA 2/22/2010

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

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect February 22, 2010, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes.

We reserve the right to 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. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request. 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 us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your health information for treatment or disclose it to a dentist, physician, or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care options. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your 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 permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your medical information to a public entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury
- to report adult abuse, neglect, or domestic violence

• to health oversight agencies
• in response to court and administrative orders and other lawful processes
• to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person
• to coroners, medical examiners, and funeral directors
• to an organ procurement organizations
• to avert a serious threat to health or safety
• in connection with certain research activities
• to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities
• to correctional institutions regarding inmates and
• as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other that photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may-but are not required to-prepare a summary or explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more that once in a 12-month period, we may charge you a reasonable cost-based fee for these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:
• we may have violated your privacy rights
• we made a decision about access to your health information incorrectly
• our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
• we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We will 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.

Provider Contact Office: CHILDREN'S DENTISTRY OF RANCHO CUCAMONGA
Telephone: 909-483-6851 Fax: 909-483-6853
Address: 9469 Haven Avenue, Suite 100 Rancho Cucamonga, CA 91730

ACKNOWLEDGEMENT OF RECEIPT
OF
NOTICE OF PRIVACY PRACTICES

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

_____
Name

_____
Signature

_____
Date

For Office Use Only

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

- ☐ Individual refuse to sign
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement.
- ☐ Other (Please Specify)

  _____
  _____