

HEALTH HISTORY UPDATE

Child's Name _____ Birthdate _____

1. Are you the child's legal guardian? Yes No
If no, what is your relationship? _____
2. Has your child received any medical care since their last dental visit? Yes No
If yes, give details _____
3. Is your child taking any medications? Yes No
If yes, what _____
4. Is your child presently under the care of a physician for any medical reason? Yes No
If yes, give details _____
5. Has your child sustained a traumatic dental injury since their last visit? Yes No
If yes, give details _____
6. Do you have any concerns about your child's dental health? Yes No
If yes, give details _____
7. Has your address or telephone number changed? Yes No
If yes, please give new information _____
8. Has your insurance company or benefits changed? Yes No
If yes, please give new information _____
9. Is your child allergic to any medicine, food or other product? Yes No
If so, what _____
10. Does your child have any medical condition (heart murmur, heart defect) Yes No
that requires antibiotics prior to dental treatment?
If so, please explain _____
11. Does your child have any rods, screws, pins or implants? Yes No
If yes, what kind? _____
12. Do you have an email address? _____
13. Do you have any other concerns? _____

My signature below indicates that I understand and have answered all the questions on the health history update to the best of my knowledge.

Signature _____ Date _____
(Parent or guardian)

Reviewed with parent _____ Date _____
(Doctor Signature)

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 the 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 service is 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 of payment is yours. It is **your responsibility** to know which services are covered or not covered. If you do not want to specific procedure done it is your responsibility to make an assistant or dentist aware of this decision. We do not check benefits at each visit. Should there be any changes in eligibility, coverage, frequencies, and 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