VILLA PARK
Pediatric Dentistry

Villa Park Pediatric Dentistry
1467 N Wanda Rd, Suite 195, Villa Park, CA 92867

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #:(____) _____ Social Security #: _____

Child's Name: _____ Child's Birthdate: ____ /____ / ____ Child's Age: _____
Last **First** **MI**

Nickname: _____ ☐ Male ☐ Female School: _____ Grade: _____

Child's Home Address: _____

Who may we thank for referring you? _____

What is the primary reason for today's visit? _____

Is your child adopted? ☐ Yes ☐ No Has any member of your family been or is currently a patient in this office? ☐ Yes ☐ No

If yes, name: _____

Dental History

Is your child currently in pain? ☐ Yes ☐ No
Is this your child's first time seeing a dentist? ☐ Yes ☐ No
Has your child experienced problems with previous dental work? ☐ Yes ☐ No If yes, explain: _____

Previous Dentist: _____ Date of Last Visit: _____ Date of Last X-Ray: _____

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Have there been any injuries to your child's teeth, jaws, falls, blows, chips, etc. ☐ Yes ☐ No
Does your child take fluoride supplements? ☐ Yes ☐ No
Has your child been seen by an orthodontist? ☐ Yes ☐ No Who? _____
Does your child brush his/her teeth daily? ☐ Yes ☐ No Does he/she require parental help? ☐ Yes ☐ No
Does your child floss his/her teeth daily? ☐ Yes ☐ No Does he/she require parental help? ☐ Yes ☐ No

Name of Parent's dentist: _____

Does/Did your child have any of the following habits? (please check)

☐ Lip sucking and Nail Biting ☐ Clenching/Grinding Teeth ☐ Tongue/Cheek Biting ☐ Mouth Breather
☐ Chewing on Objects ☐ Thumb/Finger Sucking ☐ Used Pacifier ☐ Speech Problems
☐ TMJ/TMD Pain ☐ Nursing Bottle Habits ☐ Tongue Thrust ☐ Breast Fed

Medical History

Child's Physician: _____ Phone: (___) _____ Date of last visit: _____

Address: _____

Is your child under the care of a physician? ☐ Yes ☐ No Please explain: _____

Does your child have social/personality/temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are Immunizations Current?** ☐ Yes ☐ No

Please list all medications and dosage that your child is currently taking: _____

Please list all drugs and/or things that cause your child allergic reactions: _____

Anything you would like to discuss with the Doctor in Private? ☐ Yes ☐ No

Has your child had/experienced any of the following: (please check)

Abnormal Bleeding	☐ Y ☐ N	Chicken Pox	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Mononucleosis	☐ Y ☐ N
AIDS/HIV	☐ Y ☐ N	Congenital Birth Defect	☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Recurrent/Frequent Headaches	☐ Y ☐ N
Allergies	☐ Y ☐ N	Congenital Heart Defect	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Rheumatic	☐ Y ☐ N
Anemia	☐ Y ☐ N	Diabetes	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Seizures	☐ Y ☐ N
Any Hospital Stays	☐ Y ☐ N	Endocrine System Disorders	☐ Y ☐ N	Hives	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Any Operations	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N	Sickle Cell Anemia	☐ Y ☐ N
Asthma	☐ Y ☐ N	Frequent Infections	☐ Y ☐ N	Liver/GI System Problems	☐ Y ☐ N	Sight Disorders	☐ Y ☐ N
Blood Dyscrasia	☐ Y ☐ N	Handicaps	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Significant Injuries	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Behavior/Learning Disabilities	☐ Y ☐ N	Lupus	☐ Y ☐ N	Skin Rash	☐ Y ☐ N
Breathing/Lung Problems	☐ Y ☐ N	Mentally/Physically Disabled	☐ Y ☐ N	Measles	☐ Y ☐ N	Tonsillitis	☐ Y ☐ N
Cancer/Tumors	☐ Y ☐ N	Hearing Impaired	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N	Tuberculosis (TB)	☐ Y ☐ N

Please discuss any serious medical problems your child experiences(ed): _____

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Parents Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single Family E Mail: _____

Father/Step Birthdate: ____/____/____ Home #: (___) _____ Work #: (___) _____

Name: _____ Social Security #: _____ Drivers License #: _____

Employer: _____ Occupation: _____

Cell #: _____

Mother/Step Birthdate: ____/____/____ Home #: (___) _____ Work #: (___) _____

Name: _____ Social Security #: _____ Drivers License #: _____

Employer: _____ Occupation: _____

Cell #: _____

Name of parent who resides with the child: _____

Nearest relative: _____ Address: _____ Phone: _____

Is your child covered by a dental insurance plan? ☐ Y ☐ N

Insurance Information

Primary Insurance: Is insurance provided through an employer? ☐ Y ☐ N If so please list: _____

Insurance Co. Name: _____ Phone #: (____) _____

Subscriber#: _____ Group #: _____

Insurance Co. Address: _____

Insured's Name: _____

Secondary Insurance: Is insurance provided through an employer? ☐ Y ☐ N If so please list: _____

Insurance Co. Name: _____ Phone #: (____) _____

Subscriber#: _____ Group #: _____

Insurance Co. Address: _____

Insured's Name: _____

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to Villa Park Pediatric Dentistry insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

_____
Signature Date

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and 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 Villa Park Pediatric Dentistry to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and/or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

_____
Signature Date

Medical History Review: _____
Signature Date

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TO OUR PATIENTS AND FAMILIES

Thank you for choosing Villa Park Pediatric Dentistry for your child's dental care. We consider families to be an essential participant in your child's care and wish to support and respect your needs while your child is under our care. We want you to understand your rights and responsibilities as families and patients at Villa Park Pediatric Dentistry. Your signature on this form provides consent for treatment and payment, and acknowledges receipt of other general information. If you have questions, please ask your provider.

Consent for Treatment
I hereby authorize and request the performance of dental service for my minor child. I understand that at the first appointment (examination, necessary x-rays, cleaning, topical fluoride) the doctor will explain my child's treatment needs and the various behavior management approaches. At this appointment the doctor's staff will review any associated fees. I also realize that any restorative treatment will be accomplished at a later date.

Missed/Broken Appointment Policy
Due to the limited space in our schedule and the need to provide timely service to all of our patients it is very important that you keep your scheduled appointments. It is understandable that occasionally you may need to reschedule due to an emergency or illness. We ask that you give us the courtesy of a 48 hour notice so that we will have the opportunity to use your appointed time to provide treatment for others in need. If you cancel your appointment without 48 hours notice or if you "No-Show" for your appointment then you will be required to pay a **$50.00 Non-Refundable Fee**.

Assignment of Benefits (AoB) and Release of information (RoI)
- I consent to and authorize that payment of benefits for healthcare related services be made to Villa Park Pediatric Dentistry This consent specifically authorizes Villa Park Pediatric Dentistry to release Protected Health Information (PHI) to insurers, governmental agencies and their agents for billing purposes and determination of benefits.
- I assign any benefits payable for provider services to the provider or organization providing the services
- **I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of Villa Park Pediatric Dentistry and of providers rendering services not otherwise paid by my health insurance or other payor. All charges due are payable upon receipt of the bill. If a payment is not made within 30 days after receipt of bill, a delinquent charge or interest of 18.00% (1.5% monthly rate) will be added. I agree to pay all costs of collection including attorney fees, collection fees and court costs**
- The terms of this AoB and RoI will be enforced until final payments are made for all services.
- If and when there are changes to my insurance plans, I will notify Villa Park Pediatric Dentistry and sign a new agreement.

Insurance
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 30 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary rates for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service.

AT THIS OFFICE WE FOLLOW THE GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY IN REGARD TO FREQUENCY OF X-RAYS, CLEANINGS, FLUORIDE TREATMENTS AND RESTORATIVE CARE. AS SPECIALISTS WE CONSIDER THESE GUIDELINES TO BE THE STANDARD OF CARE (BEST TREATMENT FOR YOUR CHILD). THESE GUIDELINES ARE NOT DICTATED BY DENTAL INSURANCE AND IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHETHER YOUR PARTICULAR INSURANCE PLAN WILL REIMBURSE YOU FOR THESE SERVICES. PLEASE CALL YOUR INSURANCE COMPANY WITH QUESTIONS REGARDING FREQUENCIES.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account

_____ _____
Print Patient's Name Date

_____ _____
Signature/Relationship to Patient Print Your Name

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU 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 and for other purposes that are permitted or required by law. It also describes your rights to access and control you protected health information, that may identify you and relates to your past, present, or future physical or 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 for 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 dental care and any related services. This includes the coordination or management of your dental care with a third party. For example, your protected health information may be provided to a specialist to whom you have been referred to ensure that the specialist has the necessary information to diagnose or treat you.

Payment
You protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a restoration may require that your relevant protected health information be disclosed to the dental plan to obtain approval for the restoration.

Healthcare Operations
We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. 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 authorization. These situations include: as Required by Law, Public Health issues are required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors: and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Use 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 and Required 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's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information

Your 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 that 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 purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the 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 Health Professional.

You have the right to request to receive confidential communications from us by alternate means or at an alternative location. You have the 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 have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a state 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 us or the Secretary of Health and Human Services 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 September 1 2008

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 (714) 680-9500.

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Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accounting Act of 1996 (HIPAA). I understand that this information can an will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____
Print Patient's Name Date

_____ _____
Signature/Relationship to Patient Print Your Name

Media Release

I hereby consent for Villa Park Pediatric Dentistry to use, reproduce, exhibit or distribute (in full or in part) any photograph, video, film, and/or audio recordings made of my child or his/her likeness; and/or any written extract of such recordings in which he/she may be included, for any purpose whatsoever, in any medium now known or in the future invented.

I hereby release, discharge, and agree to hold harmless Villa Park Pediatric Dentistry and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

Parent or Legal Guardian: _____
(Print name)

Signature: _____

Date: _____

Address: _____

City: _____ State: _____ Zip: _____