**NOE VALLEY SMILES FOR KIDS**
**PEDIATRIC DENTISTRY**

Date: _____

## Patient Information

Child's Full Name_____ Age _____ Sex (M) (F)

Nickname (if any) _____Birth Date _____

Whom may we thank for referring you _____

## General Information

Mother/ Father (full name) _____SSN _____ Birthdate _____

Mother/ Father (full name) _____SSN _____ Birthdate _____

Parent(s) are: Married Divorced Single Widowed Partners Child lives with: _____

Home Address _____Zip Code_____ Home Phone _____

Mother's /Father's Employer_____ Job Title_____ Cell Phone _____

Business Address _____ Work Phone _____

Mother's /Father's Employer_____ Job Title_____ Cell Phone _____

Business Address _____ Work Phone _____

E-mail Address _____ Person Financially responsible _____

Emergency Contact _____ Phone _____

How would you like us to contact you? Home Work Cell E-mail

SIGNATURE _____ Relationship _____

# Health History

Patient Name: _____ Date of Birth: _____

## Social History

What is your child most interested in?_____

Names of brothers/sister_____ Is your child adopted? (Y) (N)

Name of Pets_____

Reason for today's visit _____

Child's school_____

## Medical History

Child's pediatrician: _____Telephone #_____

Has your child had any unfavorable reactions to drugs, antibiotics, or anesthetics? (Y) (N)

If yes, please list _____

**Does your child currently have OR has your child ever had a history of any of the following?**

If you replied YES to any of the below, please explain:

| | | | | | |
|---|---|---|---|---|---|
| Allergies (if YES, see below) | (Y) | (N) | Hearing Impaired | (Y) | (N) |
| Congenital Heart Problems / Heart Murmurs / Rheumatic Fever | (Y) | (N) | Bone Disorder | (Y) | (N) |
| Premature birth | (Y) | (N) | Cancer/Malignancy | (Y) | (N) |
| Growth & Development (learning, behavioral) | (Y) | (N) | Diabetes/Endocrine | (Y) | (N) |
| Down's Syndrome | (Y) | (N) | Brain Injury | (Y) | (N) |
| Autism | (Y) | (N) | Central Nervous System/Epilepsy/Seizure | (Y) | (N) |
| Learning disabilities/ADHD/ADD | (Y) | (N) | Cerebral Palsy | (Y) | (N) |
| Asthma / Respiratory System / Pneumonia | (Y) | (N) | Hepatitis or Liver Disease | (Y) | (N) |
| Cystic Fibrosis | (Y) | (N) | GI (stomach, intestinal) / Eating Disorder | (Y) | (N) |
| Tuberculosis | (Y) | (N) | Bladder problems | (Y) | (N) |
| Anemia | (Y) | (N) | Extremities/Arthritis/Joint problems | (Y) | (N) |
| Hemophilia/Blood Disorders / Bruising | (Y) | (N) | Emotional/School Problems/Depression/Anxiety | (Y) | (N) |
| Skin Problems / Cold Sores / Canker Sores | (Y) | (N) | Hospitalizations/Surgeries | (Y) | (N) |
| Earaches/Infections | (Y) | (N) | OTHER | (Y) | (N) |

_____

_____

Is your child currently taking any **MEDICATIONS**? (Y) (N) If YES, what kind?_____

Is your child protected by immunizations? (Y) (N) _____

Is your child taking any supplemental fluoride? (Y) (N) If yes, how? _____

Does your child have an **ALLERGIC REACTION** to: (Please check all that apply) ____NO KNOWN ALLERGIES ____Medications ____Latex/Rubber ____Pollen/Dust ____Anesthetic ____ Animals(Dogs/Cats) ____Acrylic ____Dyes/Coloring ____Other Foods If so, please list: _____

## Dental History

Is this your child's dental first visit? (Y)(N) If no, previous dentist? _____Phone _____

Date of last visit _____How was his/her experience? _____ Were X-rays taken? (Y) (N)

Has your child had any injuries to teeth, mouth or head? (Y)(N) Please describe: _____

Does your child have any of the following habits? (past or present)? Please circle: Thumb/finger-sucking Pacifier

Nail-biting Lip-sucking Mouth-breathing Teeth-Grinding Snoring Bottle-feeding

Does your child currently use a bottle? (Y) (N) If yes, how often during the day? _____

Is the bottle used at night? (Y) (N) What do you put in the bottle? _____ Does your child currently nurse? (Y) (N)

How often does your child brush his/her teeth per day? _____ Do you help? (Y) (N)

How often does your child floss? _____ Do you floss your child's teeth? (Y) (N)

The permission of parent or guardian is necessary for dental treatment of a minor. I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's health status. I authorize the dental staff to perform any necessary dental services my child may need. I understand that by signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage. I further understand that all payments are due and payable on the day services are rendered.

Parent/Guardian Signature: _____ Date_____

Doctor's Signature: _____ Date_____

**NOE VALLEY SMILES FOR KIDS**

**PEDIATRIC DENTISTRY**

**Insurance Information**

Primary Insurance Company _____ Phone Number _____

Subscriber _____ Birthdate _____ Group Number _____

Secondary Insurance Company _____ Phone Number _____

Subscriber _____ Birthdate _____ Group Number _____

As a courtesy to our patients, we will file your insurance claim with the insurance company listed above for treatments your child receives. However, in the event the insurance company, for any reason, does not pay, the balance will become your responsibility, and will be billed directly to you. You understand that this contract is with Noe Valley Smiles for Kids and yourself, and you are responsible for all charges on the account.

SIGNATURE OF RESPONSIBLE PARTY _____

Relationship _____ Date _____

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Discover healthy beautiful smiles

**Informed Consent for New Patients**

Dear Parent or Guardian,

Please complete this Informed Consent for New Patients and initial all items as requested.

**Date:** _____

**Patient Name:** _____ **Parent (or Guardian) Name:** _____

**EXAM and CLEANING**

Regular exams and cleanings play an important role in proper dental health. They allow the dentist to screen for dental caries, gingival and/or periodontal issues or orthodontic needs. A cleaning, fluoride treatment, x-rays and exam are performed. Risks include but are not limited to: sensitivity or bleeding of the teeth or gums due to scaling. I understand that if I choose not to maintain regular check-ups and/or cleanings, this decision may result in decay, pain, infection, and/or orthodontic or periodontal problems.

**Initial**_____

**X-RAYS**

X-rays are used as an important diagnostic tool for the dentist. How often x-rays are taken depends on the age, risk for disease, and signs and symptoms of the patient. Our office follows the recommended guidelines from the FDA and the American Academy of Pediatric Dentistry. Many diseases of the teeth and surrounding tissues cannot be seen when your dentist examines your mouth visually. An x-ray may reveal the presence of small cavities between the teeth, infections in the bone, abscesses, cysts, developmental abnormalities and some types of tumors. It is in your child's best interest to be periodically screened with the use of diagnostic x-rays. Risks of not taking x-rays include but are not limited to: a failure to diagnose and treat conditions before signs and symptoms have developed than can threaten oral and general health. Risks from radiation exposure have been significantly reduced by improvements in technology. The benefits of dental x-rays to promote adequate and quick diagnosis outweigh the potential adverse effects. I understand if I choose to not allow x-rays to be taken, I may be asked to transfer my child to another dentist. **Initial**_____

**SEALANTS**

Sealant is a white material that is applied to the chewing surface of the molars and bicuspids where decay occurs most often. It acts as a barrier protecting the decay prone areas of the teeth. Grooves and depressions are difficult to keep clean because the toothbrush bristles do not reach into them. The sealant forms a thin covering that keeps food and plaque out, decreasing the chance of decay. The tooth is cleaned and conditioned to help the sealant adhere the chewing surface. The sealant is then painted on the tooth into the deepest pits and fissures. Risks include, but are not limited to: need for replacement, allergic reaction to the materials and/or possible decay if post-operative instructions are not followed properly. I understand that my child may still get decay between his or her teeth even with sealants still intact. The alternative to sealants is to do nothing and decay may occur as a result of this decision.

**Initial**_____

**FLUORIDE TREATMENT**

Fluoride is a naturally occurring element that prevents tooth decay systemically when ingested during tooth development and topically when applied to erupted teeth. Topically applied fluoride provides local protection on the tooth surface. Topical fluorides include toothpaste, mouth rinses and professionally applied gels and rinses. In addition to their use in caries prevention, topical fluorides may be used to control established carious lesions. Systemic fluorides are those that are ingested into the body and became incorporated into forming tooth structures. Benefit: Fluoride helps to prevent tooth decay by making teeth stronger. Fluoride can be applied topically, in which case a gel, paste, rinse, or solution is placed on the teeth where fluoride acts directly on the tooth enamel. The application of concentrated fluoride solutions or gels may result in a reduction of dental caries. The alternative is conventional methods of dental caries prevention at home: brush twice daily with fluoride toothpaste, floss and avoid frequent snacking. Fluoride is the most effective caries-prevention agent available today. It is considered safe when properly used. The ingestion of high concentrations can lead to nausea, vomiting, dental fluorosis, which is a chalky white to brown discoloration of the permanent teeth. The complications or overdose may require medical assistance or hospitalization and even death. Consequences of not performing treatment: being deprived of the benefit of topical fluoride application and its property to prevent tooth decay and control the cavities already present.

**Initial**_____

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and to ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

**Parent or Guardian Signature**_____ **Date**_____

**Witness (Doctor or Staff):** _____

**Noe Valley Smiles and Braces**

**ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES ("Acknowledgement")**

**Last Updated April 1, 2011**

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

**Please Note: It is your right to refuse to sign this Acknowledgement.**

*Dental Office Use Only*

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.

__ A communication barrier prevented us from obtaining acknowledgement.

__ The individual was unwilling to sign.

__ Other:_____

_____ _____
Staff Member Signature Date

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**Patient Name** _____

**Date** _____

## Confirmation & Cancellation Policy

Noe Valley Smiles & Braces understands that your time is very valuable and we hope you agree that our time is equally valuable. It is with that understanding that we have implemented a **48 business hour cancellation policy**. ***If an appointment is cancelled with less than 48 business hours notice you will be subject to a $75 cancellation fee based on the amount of time that you have reserved.***

**Signature** _____

## Mercury Free Practice

Noe Valley Smiles & Braces is pleased to inform you that we are a mercury free practice. In the past the most commonly used filling material was amalgam which contains mercury and is silver in color. Today in our office we use a material called composite resin. The plastic resin material bonds directly to the tooth and is much more aesthetically pleasing. Some insurance companies will only pay for an amalgam restoration leaving you with a slight difference in your balance.

**Signature** _____

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# Financial Agreement

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore, we offer the following payment options:

1) Flexible payment plans of up to 6 months upon approval with Care Credit®. Approval must be received prior to treatment date.
2) Cash, Check or Visa/MasterCard/Discover/American Express

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is contract between you and your insurance company; therefore, all charges are your responsibility.

Once an insurance claim reaches 60 days the estimated insurance balance will become your responsibility. You will have to contact your insurance provider for reimbursement.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am responsible for all collection costs incurred by the dental office and on a returned check, a fee of $35.00.

Name of Patient:_____ Date of Birth:_____

**Signature of Patient or Legal Guardian:** _____ **Date:**_____