DATE: _____

Five Cities Pediatric Dental Group & Orthodontics

Five Cities Pediatric Dental Group would like to welcome your family to our office. Our goal is to make every child's visit fun, pleasant and educational. Our practice is focused on preventive care. We emphasize good oral hygiene that will allow your child to have a healthy smile that lasts a lifetime.

Tell us about you: (circle one)

☐ Mother's Information ☐ Stepmother ☐ Guardian

Name:_____

Hm #: _____ Cell #: _____

Date of birth :_____ _____

E-mail: _____

DL#:_____ State: _____

Tell us about you: (circle one)

☐ Father's Information ☐ Stepfather ☐ Guardian

Name:_____

Hm #: _____ Cell #: _____

Date of birth: _____

E-mail: _____

DL#:_____ State: _____

Person Responsible for the Account:

Name:_____ Relation:_____

Address:_____

_____

Home #:_____ Cell #: _____

Employer:_____

SSN: _____

Parent's marital status:

Single Married Partnered Widowed Divorced Separated

Tell us about your child:

Child's name: _____

Birth date: _____ Male Female

School: _____ Grade: _____

Home address: _____

_____

Emergency contact (besides parent): _____

Relation:_____ Ph#:_____

Siblings seen by us: _____

_____

Primary Dental Insurance:

Insurance Co. Name: _____

Subscriber name: _____

ID# or SSN: _____

Birth date: _____ Relation to patient: _____

Employer:_____

Group #: _____

Secondary Dental Insurance:

Insurance Co. Name:_____

Insurance Co. Phone #: _____

Subscriber name: _____

SSN#/ID #: _____

Birthdate: _____ Relation to patient: _____

Employer:_____

Five Cities Pediatric Dental Group & Orthodontics

Medical History:

Patient name: _____ Date: _____

State the general condition of the child's health. Please give details: _____

NAME of pediatrician or physician(s): _____

Has your child ever had any surgeries? (circle one) Yes No

If yes, for what condition and when: _____

Are your child's vaccinations up to date? Yes No

Has your child received medication in the past other than antibiotics? Yes No

If yes, please list medications: _____

Has your child had any history of the following? (circle yes or no)

Asthma	Yes	No	Heart condition	Yes	No
Inhaler ever prescribed	Yes	No	Heart murmur	Yes	No
Bleeding disorder	Yes	No	Heart surgery	Yes	No
Autistic Spectrum Disorder	Yes	No	Rheumatic fever	Yes	No
Attention Deficit Disorder (ADD)	Yes	No	Brain injury	Yes	No
Attention Deficit Hyperactivity Disorder (ADHD)	Yes	No	Fainting/Seizures	Yes	No
Sight or hearing limitations	Yes	No	Epilepsy/Convulsions	Yes	No
Immune disorder (including HIV or AIDS)	Yes	No	Diabetes	Yes	No
Cancer, tumors or growths	Yes	No	Hepatitis/Jaundice	Yes	No
Gastric reflux (GERD)	Yes	No	Kidney Disease	Yes	No
Sleep apnea (OSAS)	Yes	No	OTHER: _____		
			_____		

Is your child allergic to or has he/she had a reaction to any of the following?

Local anesthetic (Novocain)	Yes No	If yes, what:	_____
Penicillin, Amoxicillin or other antibiotic	Yes No	If yes, what:	_____
Aspirin or other analgesic	Yes No	If yes, what:	_____
Latex rubber	Yes No	If yes, what:	_____
Any metals (Nickel, tin, silver)	Yes No	If yes, what:	_____
Any family history of severe allergies	Yes No	If yes, what:	_____

Dental History:

How did you hear about our office? _____

Has your child seen a dentist before? (circle one) Yes No

If yes, date of the last dental exam _____ Name of previous Dentist:_____

Has your child experienced an unfavorable medical or dental visit? Yes No

If yes, explain why_____

Does your child have any of the following habits: Bottle, cup, or breastfeeding during night? Past Present N/A

Thumb or finger sucking / pacifier use? Past Present N/A

Other? _____

How many cups of juice or other sweetened beverages are consumed per day? 1 2 3 4 or more

Number of meals eaten per day? _____ Number of snacks per day: _____

What is your greatest dental concern for your child? _____

For how long have you had this concern? _____

How do you think your child will respond at the dentist?_____

Financial Policies, Arrangements, and Conditions

Welcome to our practice! We are pleased you have selected our office for your child's dental care and we value the confidence you have expressed in choosing Five Cities Pediatric Dental Group (FCPDG). We understand that parents are concerned not only with the quality of their children's dental care, but also with the costs of professional services. Therefore, we have outlined below the financial policies of this office:

- Full payment of your estimated patient portion/responsibility is due at the time of service by whomever accompanies your child. Please note: the parent, grandparent, or guardian/caretaker accompanying the child is responsible for full payment at the time of service/treatment. This includes co-payments and deductibles.

- We accept cash, checks, money orders, and Care Credit. If you would like more information regarding a payment plan through Care Credit, please ask the receptionist prior to treatment. Generally, Care Credit is only accepted for charges in excess of $500.00. We also accept Visa, Mastercard, or Discover.

- All checks returned due to non-sufficient funds (NSF) or closed accounts will be processed through the San Luis Obispo County District Attorney's Bad Check program. A $35.00 NSF fee will be applied to any returned check. We will forward any uncollected amounts to a collection agency. A late payment fee of $35.00 plus 1.5% interest per monthly billing cycle may be applied to account balances over 45 days old, regardless of insurance involvement.

- Insurance eligibility & benefits will be checked PRIOR to your child's appointment. To facilitate this process, we **MUST** have your child's insurance information (subscriber ID number or SSN, carrier name/phone number, subscriber name, DOB, & address, etc.) at least **48 HOURS** prior to their appointment. Although we will check insurance eligibility & benefits, this should not be considered a guarantee of payment. The guardian(s) is/are ultimately responsible for verifying that insurance is active and that dependent(s) is/are eligible for insurance benefits on the day of the appointment. *If your child is not eligible under the insurance plan, or if we are not able to verify insurance benefits, payment for services is due on the date they are rendered.*

- If you provide us with accurate insurance information, we can bill your insurance carrier as a courtesy to you. **At the time of treatment, we will ESTIMATE and collect from you your deductible and patient portion/responsibility (according to the information given to us by you & your insurance company). Please note that this amount is only an estimate and that you are responsible for all amounts not paid by your insurance company, including but not limited to deductibles, co-insurance, fees for non-covered benefits, and/or additional co-insurance due to alternate benefits (downgrades) applied by your insurance company.** After submitting your insurance claim, we will wait 45 days for payment from your insurance company. If we have not received payment after 45 days, fees for completed services are due ***immediately***, even if the claim is re-submitted to insurance or appealed. At this point, you may contact your insurance company for payment of their portion directly to you. If claim payment is denied or is less than our estimate of coverage, the guardian(s) are responsible for the remaining balance. NOTE: your child may receive treatment at the lowest possible cost by utilizing a dental provider that participates in your insurance company's or insurance program's provider network. *It is the responsibility of the subscriber to confirm whether our dentists participate in their insurance network.*

TO CANCEL OR RE-SCHEDULE AN APPOINTMENT, WE REQUIRE *TWO (2) BUSINESS DAYS* ADVANCE NOTICE from you, otherwise the appointment is considered broken. **We charge $50.00 per broken or missed appointment**. Appointments are confirmed upon booking. Please remember, the time we reserve for your child could be used by another child (possibly a child in pain).

Please note if you arrive more than 15 minutes late for your appointment, the appointment may be considered a missed appointment, and may need to be rescheduled. We will attempt to accommodate you at a different time the same day, if our schedule allows.

I certify that my child/children is/are covered under _____ Insurance Co., and hereby give lifetime authorization for payment of all insurance benefits directly to Five Cities Pediatric Dental Group for services rendered. **I understand that I am financially responsible for all charges whether or not they are covered by insurance.** In the event of default, I agree to pay all costs of collection and reasonable attorney's fees. I hereby authorize FCPDG to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether electronic or manual, and agree that a photocopy of this agreement shall be as valid as the original. I authorize FCPDG or its agent(s) to contact me or my childrens' financially responsible parties via any of the telephone numbers listed in my childrens' account information (including cellular numbers) for the purposes of obtaining insurance coverage information, billing purposes, or collections.

Your signature below acknowledges that you have read the above Financial Policy and agree to its terms and conditions.

Parent/Legal Guardian (please print): _____

Parent/Legal Guardian signature: _____

Patient's name(s): _____

Date: _____ Witness: _____

Five Cities Pediatric Dental Group & Orthodontics

General Consent

The undersigned hereby authorizes the pediatric dental specialists of this group, following explanation of the procedure(s) involved, to perform any and all forms of treatment, medication and therapy, that may be indicated in conjunction with the care of the above named child and further authorizes and consents that the group dentists may choose and employ such assistance as they deem appropriate. The undersigned understands that previous to treatment, full explanation of procedure(s) involved will be given by one of the pediatric dental specialists and/or their staff. I authorize and consent to the release of all information concerning my child's oral health and treatment history to third party payers (insurance companies) and to other health professionals; any exceptions are indicated below. This consent is to remain in effect until canceled in writing.

I also attest that my responses on the preceding forms are true and correct and that I have not omitted any pertinent health information. I will not hold Five Cities Pediatric Dental Group or its dentists responsible for any consequences resulting from errors or omissions in this form.

Guardian's signature: _____

Date: _____ Relation: _____

Patient name: _____

Patient name: _____

Patient name: _____

Specific exceptions to my consent to the release of information concerning my child's oral health and treatment history:

_____

_____

Reviewed by Dr. _____ Date: _____

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

I, as the legally responsible guardian of _____, acknowledge I have received from Drs. Lauriente and Perez Martinez a copy of the Dental Materials Fact Sheet dated May 2004.

_____ _____
Legal Guardian Signature Date

_____
Legal Guardian Name (Please print)

_____ _____
Witness (Dentist or Staff member) Date

Acknowledgement of Receipt of Privacy Practices Notice

You May Refuse to Sign This Acknowledgement

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

Patient Name: _____

Patient Name: _____

Patient Name: _____

Guardian Signature: _____

Date: _____ Relation: _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's name _____

Relationship to Patient _____

For Office Use Only

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

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify):

RECEIVED BY: Employees Initial _____