Five Cities Pediatric Dental Group & Orthodontics

DATE: _____

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.

Parent 1 info:

Do you have legal custody of this child? YES NO

Name:_____

Hm #: _____ Cell #: _____

Date of birth :_____

E-mail: _____

SSN _____

Parent 2 info:

Do you have legal custody of this child? YES NO

Name:_____

Hm #: _____ Cell #: _____

Date of birth: _____

E-mail: _____

SSN _____

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 Other

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 #: _____

Birth date: _____ 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: _____

Has your child received **all** recommended vaccinations? Yes No

Has your child received medication (including inhalers) in the past other than antibiotics? Yes No

If yes, please list medications and/or inhalers: _____

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

Asthma	Yes	No
Inhaler ever prescribed	Yes	No
If yes, what type/name? _____		
Bleeding disorder	Yes	No
Autism Spectrum Disorder	Yes	No
Attention Deficit Disorder (ADD)	Yes	No
Attention Deficit Hyperactivity Disorder (ADHD)	Yes	No
Speech delay	Yes	No
Immune disorder (including HIV or AIDS)	Yes	No
Cancer, tumors or growths	Yes	No
Gastric reflux (GERD)	Yes	No

Heart murmur or condition	Yes	No
Heart surgery	Yes	No
Rheumatic fever	Yes	No
Brain injury	Yes	No
Fainting/Seizures	Yes	No
Epilepsy/Convulsions	Yes	No
Diabetes	Yes	No
Hepatitis/Jaundice	Yes	No
Kidney Disease	Yes	No
Taking bisphosphonates?	Yes	No
Sight or hearing disorder	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, which antibiotic? _____
Aspirin or other analgesic	Yes	No	If yes, what: _____
Latex rubber	Yes	No	If yes, what: _____
Metal allergies (Nickel, tin, silver)	Yes	No	If yes, what: _____
Any other food or drug allergies	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? YES NO

If yes, date of last dental exam: _____ Name of dentist or office name:_____

Number of times teeth brushed per day: 0 1 2 Is fluoride toothpaste used? YES NO

Are teeth flossed daily: YES NO 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

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

What is your greatest dental concern for your child? _____

For how long have you had this concern? _____

How does your child respond to new environments?_____

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 & Orthodontics. We understand that parents are concerned not only with the quality of their children's dental care, but also with the cost of healthcare services. Therefore, we have outlined below the financial policies of our practice for your consideration:

- Full payment of your child's estimated patient financial 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, Visa, Mastercard, Discover, and Care Credit. If you would like more information regarding a payment plan through Care Credit, please ask the coordinator prior to treatment. Generally, Care Credit is only accepted for charges in excess of $500.00. We do not accept American Express.

- 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 reserve the right to forward aging balances to a third-party 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. *Please note, appointment scheduling may be restricted for family accounts with aging balances.*

- 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 **2 BUSINESS DAYS** 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, full 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 is contracted with your insurance carrier's provider network. **It is the sole responsibility of the parents or guardians to confirm whether our dentists are contracted in their insurance network.** This can be done by searching the provider directory issued by the insurance carrier.

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 appointment missed, broken or canceled short notice**. Please remember, the time we reserve for your child could be used by another child (possibly a child in pain). Appointments are confirmed upon booking, but may require follow-up confirmation response as needed. 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 the patient care schedule allows.

I certify that my child/children is/are covered under _____ (**dental** insurance carrier), 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 dentists 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 professional 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 information concerning my child's oral health and treatment history to third party payers (insurance carriers) and to other consulting health professionals. 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 these documents.

Signature: _____

I am a parent or guardian with legal custody (circle one): YES NO

Date: _____ Relation: _____

This consent applies to the following other children or siblings:

Patient name: _____

Patient name: _____

Patient name: _____

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 _____

Giancarlo Lauriente, DDS
Specialist in Pediatric Dentistry
Certified, American Board of Pediatric Dentistry

Irma Perez Martinez, DMD, MS
Specialist in Pediatric Dentistry
Specialist in Orthodontics
Certified, American Board of Pediatric Dentistry

Five Cities Pediatric Dental Group & Orthodontics

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Appointment Policy

We are deeply concerned about the dental health of all our patients, and look forward to seeing them for their scheduled appointments. We pride ourselves in specially reserving the dentist's time as well as the time of our qualified dental assistants for each appointment. We make a concerted effort to avoid overbooking our schedule so that we can provide the best service in a timely manner to all our patients, without excessive wait times. Please remember, the time we reserve for your child could be used by another patient, possibly a child with urgent needs or one that is in pain. A broken appointment or one that is canceled or re-scheduled without two (2) business days advance notice negatively affects the level of care we are able to provide to all our valued patients.

TO CANCEL OR RESCHEDULE AN APPOINTMENT, WE REQUIRE TWO (2) BUSINESS DAYS ADVANCE NOTICE.

Please note, we do assess a $50 fee (per child) for appointments broken, canceled, or rescheduled without two (2) business days advance notice.

Families that cancel appointments with the required two (2) business days advance notice will not be charged any cancelation or rescheduling fees. We understand life brings the occasional illness or circumstance that can cause an appointment to be broken or canceled short notice. With this in mind, we are happy to waive the $50 fee on one (1) occasion per child during an 18 month rolling time period. This fee waiver will be granted regardless of the reason for breaking the appointment or canceling short notice. Once this single fee waiver has been applied to the child within the aforementioned time period, we are unable to grant additional fee waivers for other appointments broken, canceled, or rescheduled short notice, regardless of reason (*including for repeated illnesses*).

In order to reserve your child's appointment, it is critically important that parents respond to appointment confirmation requests from our front office. If we do not receive confirmation from you, we may need to release the appointment to another patient. Thank you most kindly for responding to our confirmation calls or messages. If a patient arrives 15 minutes or more late for their appointment, every effort will be made to accommodate the appointed needs of the patient within the limits of our schedule at the time of their arrival. If we are unable to accommodate the late arrival, the appointment will be considered canceled short notice. The $50 fee will be considered for waiver if not already waived within the preceding 18 months.

Thank you for reading this and acknowledging our appointment policy. We look forward to working with you in providing high-quality oral health care for the children & adolescents of our community.

Responsible party signature: _____ Date: _____

Responsible party name (printed): _____