Welcome to Temecula Kids Dentistry

Patient's Name: Last First Middle		Date:
Preferred Name:	Date of Birth: Age:	☐ Male ☐ Female
School Name / Grade:		Last Dental Visit:
Brothers / Sisters (Name & age):		
Home Address:	City:	Zip:
Home Telephone Number:	Mobile Phone Number:	
Email Address:		
How did you hear about our office?		

Parent's Information:
Name:
Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐
Relationship to child:
Address (if different):
Home Phone:
Mobile Phone:
Driver's License #:
Occupation:
Employer Name:
Employer Address:
Parent's Dentist:

Parent's Information:
Name:
Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐
Relationship to child:
Address (if different):
Home Phone:
Mobile Phone:
Driver's License #:
Occupation:
Employer Name:
Employer Address:
Parent's Dentist:

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single

PRIMARY INSURANCE
Name of Insured:
Date of Birth:
Social Security #:
Name of Insurance Company:
Insurance ID #:
Insurance Address:
Insurance Telephone #:
Group or Plan Number:

SECONDARY INSURNACE
Name of Insured:
Date of Birth:
Social Security #:
Name of Insurance Company:
Insurance ID #:
Insurance Address:
Insurance Telephone #:
Group or Plan Number:

In case of emergency, contact:	Phone #:

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Patient's Name: _____ First Middle Last	Birth date:
MEDICAL HISTORY	
1. Does your child have a health / medical problem? Explain:	☐ Yes ☐ No
2. Is your child under the care of a physician?	☐ Yes ☐ No
If yes, since when and why?	☐ Yes ☐ No
Name of physician:	
3. Is your child receiving any medication?	☐ Yes ☐ No
Name(s) of medication(s):	
4. Is your child allergic to penicillin, antibiotics or other drugs? Explain:	☐ Yes ☐ No
5. Is your child allergic to or sensitive to any metals or latex?	☐ Yes ☐ No
6. Does your child have any allergies?	☐ Yes ☐ No
7. Has your child had any serious illness? Explain:	☐ Yes ☐ No
8. Has your child ever had surgery? Explain:	☐ Yes ☐ No
9. Does your child have a heart murmur?	☐ Yes ☐ No
10. Does your child experience severe or prolonged bleeding?	☐ Yes ☐ No
11. Does your child have any immune function deficiency?	☐ Yes ☐ No
12. Has your child tested positive for hepatitis?	☐ Yes ☐ No
13. Is your child subject to nervous disorders?	☐ Yes ☐ No
14. Does our child have frequent headaches?	☐ Yes ☐ No
○ Has your child had history of (Circle Response): diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss, HIV.	
15. Describe any other medical concerns:	

DENTAL HISTORY	
1. What is your chief concern today?	
2. Is this your child's first visit to a dentist? If not, when was the last visit to the dentist?	☐ Yes ☐ No
3. Are your child's teeth brushed once or more a day by an Adult?	☐ Yes ☐ No
4. Are your child's teeth flossed once or more a day by an Adult?	☐ Yes ☐ No
5. Does your child have / had a habit with a pacifier / finger / thumb?	☐ Yes ☐ No
6. Does your child receive Fluoride supplement?	☐ Yes ☐ No
7. Did your child have any cavities noted in the past?	☐ Yes ☐ No
8. Were any teeth (baby or permanent) removed by extraction?	☐ Yes ☐ No
9. Has there been any injury to teeth, such as falls, blows, chips, etc.?	☐ Yes ☐ No
10. Has your child had any problem with dental treatment in the past?	☐ Yes ☐ No
11. Has your child ever received local anesthetic?	☐ Yes ☐ No
12. Is there a history of dental decay or missing teeth in the family? Explain:	☐ Yes ☐ No
13. Has anyone in the family, including parents had orthodontics?	☐ Yes ☐ No
14. What does your child usually eat for snack?	
15. What does your child drink on a daily basis?	
16. How would you rate your child's attitude toward medical / dental visits?	☐ Good ☐ Anxious ☐ Negative
17. Describe any other dental concerns:	

Welcome to Temecula Kids Dentistry

Thank you for choosing Temecula Kids Dentist, office of Dr. Mike Lee.

Our office practices patient-centered, pediatric dentistry in Temecula, where each child is treated like our own. We provide a unique dental experience that is fun, affordable, and caring. We provide a unique dental experience that is fun, affordable, and caring. Our staff takes pride in your child's health, comfort, and safety and we provide only the highest quality dentistry with new dental techniques, equipment and materials. We believe in mercury-free dentistry, high tech dentistry, and fear free dentistry.

We are committed to provide quality dental care to your child and we will strive to treat your child like our own.

The following is a statement of our Financial Policy that we require that you read and sign prior to any treatment. Please understand that this financial policy is enforced to keep costs at a reasonable level, thus preventing frequent fee increases. We hope that you communicate with us to avoid additional fees. This also allows us to concentrate on what we do best – caring for your child.

Appointment Policy:

Parents are always welcome in our office. If your child is under the age of six, we ask that you schedule a morning appointment. Younger children do better in the morning, when the child is well rested.

We require a minimum of 24 hours advance notice for missed appointments. Cancellation within 24 hours will result in a cancellation fee of $25 for missed appointments per child. Appointment time is reserved for your child. Please respect our time by keeping scheduled appointments.

Insurance:

Payment is due in full for each appointment.

If you have insurance, we may accept assignment for your child's primary insurance benefits and we will collect your **ESTIMATED** copay. We cannot know how much your insurance will cover until insurance payment is received.

Your insurance policy is a contract between you and your insurance company. Your benefits are not determined by our office. Our relationship is with you, not with the dental insurance company.

As a courtesy, we will file your insurance benefits, but ultimately **you are responsible** for all dental treatments. In the event that your insurance company has not paid their portion within 60 days, the balance will become your responsibility.

Finance Charges:

An interest charge will be added to your account balance over 60 days old. This fee will equal 12% APR.
Unpaid Accounts: Account 90 days past due may be sent to a collection agency or settled in small claims court. In these events, you will be responsible for minimum $100 collection fee and/or any court fees incurred.

Notice of Privacy Practice (HIPPA)

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails and/or letters).

Patients Rights

Access: You have the right to look at or get copies of your health information. If you request copies we will charge you for each page, staff time to locate and copy the information, and postage if you want the copies mailed.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.

Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means.

Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information, you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Mike Lee.

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Child's Name: _____ Birth Date: _____

Today's Date: _____

Financial Responsibility and Assignment of Benefits

As parent(s) / guardian(s) of my child, I / We authorize Dr. Mike Lee to examine and treat my child as necessary. 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 on the day services are rendered.

By signing below, I attest that I reviewed the appointment policy, insurance policy, and our financial policy on page three and I am a legal guardian who can make dental decision(s) for my child.

Parent(s) / Guardian Signature _____ Print name: _____

Medical / Dental History

I understand that the health information is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical status. I will notify Dr. Lee of any medical changes prior to any appointment.

Parent(s) / Guardian Signature _____ Print name: _____

Email Policy

Our office utilizes unencrypted emails as a form of communication. There is some risk that sensitive or confidential information may be intercepted by unauthorized third parties. We utilize email as an adjunct to confirm appointments, send educational information, to communicate between Dr. and patients, and for accounting purposes. We will not sell or release your email. I understand that I can change my mind any time and request that we add / remove the email address.

By providing my email address, I understand the risk associated with emails and accept email as another form of communication.

Email Address: _____

Notice of Privacy Practices (Hippa) (page 4)

I authorize the Dr. Lee and staff to obtain, use and disclose my child's Protected Health Information to carry out treatment, payment activities, and healthcare operations. This information will include but is not limited to my child's health history, diagnostic records, diagnosis and treatment provided.

Parent(s) / Guardian Signature _____ Print name: _____