PATIENT INFORMATION

Child's Name: _____ Nickname: _____
DOB: _____/_____/_____ Age: _____ ◯ Male ◯ Female
Address: _____

Parent/Guardian Information

Parent/Guardian Name: _____ Relationship to Patient: _____
DOB: _____/_____/_____ Email: _____
Home/Cell Phone: _____ 2nd Phone: _____

Parent/Guardian Name: _____ Relationship to Patient: _____
DOB: _____/_____/_____ Email: _____
Home/Cell Phone: _____ 2nd Phone: _____

Insurance Information

Dental Insurance: _____ SSN #/Member ID: _____
Policy Holder's Name/Responsible Party: _____
Employer: _____ Job Title: _____

Secondary Insurance? ◯ Yes ◯ No
Dental Insurance: _____ SSN #/Member ID: _____
Policy Holder's Name/Responsible Party: _____
Employer: _____ Job Title: _____

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have an authorization allowing this person to accompany your child. The person bringing your child will need to present a photo identification at time of service. If you choose to authorize a designated adult to accompany your child to their appointments, please fill out the section below or you can choose not to designate someone at this time.

Authorization for a Designated Adult to Accompany Patient

Name: _____Relationship to Patient: _____
Home/Cell Phone: _____ Email: _____

I authorize the above named to make any dental and medical decisions, including accompanying my child to clinic visits and consent to any changes in the treatment plan as they may arise at the time of the treatment, where the minor is not accompanied by either parents or legal guardians, and may not be feasible or practical to contact them. I agree to pay for my portion of the services provided to my child same day, if any, as the treatment is rendered.

◯ I do not wish to assign a designated adult to accompany my child to appointments at this time.

Parent/Guardian Name: _____ **Patient Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

Bethel Kids DENTAL
531 W. Kettleman Lane, Lodi, CA 95240
1660 W. Yosemite Ave. #1, Manteca, CA 95337
3633 Bradshaw Rd. #A-D, Sacramento, CA 95827

HEALTH HISTORY FORM

Dental History

◯Yes ◯No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____
◯Yes ◯No Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain: _____
◯Yes ◯No Does your child suck a finger, thumb, or pacifier (please circle)? If yes, when? _____
◯Yes ◯No Does your child go to bed with a bottle or sippy cup? If yes, what is in it? _____
◯Yes ◯No Does your child snack frequently? What are their favorite snack foods? _____
◯Yes ◯No Has your child had local anesthetic? If yes, were there any problems? _____
◯Yes ◯No Has your child ever been sedated for dental treatment? If yes were there any problems? _____
◯Yes ◯No Have your child's teeth ever been injured? Which teeth: _____
◯Yes ◯No Has your child or anyone in your immediate family ever had a cold sore or other mouth ulcer? Please describe: _____
◯Yes ◯No Does your child use a fluoride toothpaste?
◯Yes ◯No Does your child begin to smoke cigarettes or use any tobacco products?

Please check if your child is having problems with any of the following:

◯Cavities ◯Color of Teeth ◯Grinding of Teeth ◯Gum Infections ◯Jaw Sounds
◯Mouth Breathing ◯Orthodontics ◯Sensitive Teeth ◯Trauma ◯Toothache
Other: _____

Medical History

Child's Physician/Pediatrician: _____ Phone: _____
◯Yes ◯No Is your child in good health? Date of last physical exam: _____
◯Yes ◯No Has your child ever had a health problem? _____
◯Yes ◯No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: _____
◯Yes ◯No Is your child currently taking any medications? Please give medication, dose, and reason: _____
◯Yes ◯No Is your child allergic to any medications? Any food? If yes, please list what medication and/or food: _____
◯Yes ◯No Are your child's immunizations current?
◯Yes ◯No Have you ever been told that your child needs to take antibiotics before dental treatment?

Please check if your child has been treated for any of the following:

◯Abuse ◯Cancers/Tumors ◯Heart Murmurs ◯Sickle Cell Disease
◯ADHD ◯Cerebral Palsy ◯Hepatitis ◯Significant Injuries
◯Adverse Drug Reaction ◯Congenital Birth Defect ◯HIV/AIDS ◯Snoring
◯Anemia ◯Diabetes ◯Liver/GI Disease ◯Speech/Hearing Issues
◯Asthma/Breathing Problems ◯Endocrine/Growth Problems ◯Mental Delays ◯Spina Bifida
◯Autism ◯Eyesight Problems ◯Personality Problems ◯Tonsil Problems
◯Blood Transfusion ◯Frequent Infections ◯Recurrent Headaches ◯Tuberculosis
◯Blood Disorders ◯Heart Disease ◯Seizures
Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. 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.

Patient Name: _____

Parent/Guardian Signature: _____ **Date:** _____

INFORMED CONSENT

Exams/X-rays/Fluoride Treatment

For the first visit and periodical exam, we perform comprehensive examinations, take necessary radiographs, and give fluoride treatments to ensure that our patients are in best oral health. The frequency of radiographs being taken depends on patient's oral hygiene and caries risk assessment. I understand that my child will be receiving a dental examination from Dr. Opinga and/or his staff members. I understand that x-rays may be taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Dental Cleaning

I authorize Dr. Opinga and/or his staff members to clean my child's teeth today.

Drugs and Medication

I understand that antibiotics, analgesics, and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

Medical Photography Consent

I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification, submission of insurance claims, and dental treatment.

Optional Photography Consent

I consent to having my child's photo taken and displayed in the office as part of contests or bulletin boards.
◯ I consent ◯ I do not consent

I consent to having my child's photo taken and posted as part of online social media including, but not limited to: the office website and blog; Facebook, Yelp and Instagram.
◯ I consent ◯ I do not consent

Authorization and Release

I hereby certify that I have read and understand the consent form. I affirm that that information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any change in my personal contact information and the medical status of my child. I authorize the dental team to perform the necessary dental service my child need including, but not limited to, examination, prophy, radiographs, and fluoride treatment. I hereby certify that I understand and have been informed of the risks, benefits, and alternatives of the provided dental procedures.

Parent/Guardian Name: _____ **Patient Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

OFFICE POLICIES

Parent/Guardian Policy

I acknowledge that the policy of Bethel Kids Dental is for a legally responsible parent or guardian to be present for all dental appointments. If someone other than the parent or legal guardian accompanies your child to their visit, they must have a signed parental authorization/consent on file, or we reserve the right to reschedule the appointment.

It is not allowed for parents or guardians to leave or abandon their child in the office during dental exam or treatment and be picked up by any ride sharing services at a later time. Unaccompanied children will not be released to anyone who is not the parent or guardian on file. The office will not be responsible for any unaccompanied children and the parent or guardian will waive all liabilities from the office for anything that may happen to the unaccompanied child while in the office without their parent or guardian. We will contact the appropriate local authorities for further instructions if the parent or guardian is unreachable or unavailable after attempt is made by the office to contact the parent or guardian on file.

Cancellation and No Shows

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, we require at least a 24-hour advanced notice. This courtesy makes it possible to give your reserved room to another patient who would like it. Repeated cancellations with a maximum of three missed appointments without notice will result in loss of future appointment privileges. We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We, of course, would appreciate the same courtesy from you. If you have any questions or issues that are preventing you from keeping your appointments, please call us ahead of time at (209) 400-2018 and we will gladly reschedule your appointment to a more convenient time.

Requesting a new BIC or replacement BIC Card (For Medi-cal Dental Insurance)

If you did not receive your card, lost your card, your card was stolen, or the card you received in the mail has the wrong information on it, you may ask for a BIC from your local county social services office. For San Joaquin County, you may call and ask for a Benefit Identification Card (BIC) by contacting the BIC Issuance Desk at 209-468-1328.

HIPAA Notice of Privacy Practices Acknowledgement, Consent, and Authorization

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices. I understand and consent to my child's medical information being used within the guidelines of The Health Insurance Portability and Accountability Act (HIPAA). I understand the terms and authorize Bethel Kids Dental to disclose my child's dental information to practitioners involved in my child's care and parties I authorize to receive my child's dental information.

Dental Materials Fact Sheet

I acknowledge that I have received a copy of the Dental Materials Fact Sheet of May 2004.

Parent/Guardian Name: _____ Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

FINANCIAL POLICIES

Although our office will gladly e-file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. You are required to provide your most current insurance information prior to every visit and as needed throughout care. Insurance plans can vary greatly, and some companies arbitrarily select certain services that they will not cover. I authorize Bethel Kids Dental to collect payment from the insurance company. I understand that the insurance company may reimburse only a portion of my bill and that I am ultimately responsible for the full payment. If the insurance company denies a claim for any reason at any time, I understand that I am directly responsible for the payment of the outstanding amount. A member of our Billing Department will notify you if there's any unpaid balance in your account. We understand that many can experience financial difficulties at any moment in time. If this is the case, please contact our Billing Department so that we may assist you in making payment arrangements. Bethel Kids Dental accepts Cash or Credit Card payments only. INITIALS: _____

UNPAID/UNCOLLECTED BALANCE

Any unpaid and uncollected balances beyond 90 days will be referred to an outside collection agency after notice of non-payment and balance due is sent. In the event that your account is turned over for collections, the responsible party agrees to pay all additional fees incurred in the collection of the debt. These fees include the balance and any fees associated in collecting the payment and attorney's fees. During this time, we will not be able to see your kids for additional services in our office until the unpaid/uncollected balance is paid or payment arrangements is made. INITIALS: _____

TERMS OF PAYMENT FOR SELF-PAY

In the event that you do not have health insurance, or you know in advance that a specific service will not be covered by your insurance company, you will be responsible for making a payment prior to rendering services during that day at our office. You need to pay the full amount at each visit. INITIALS: _____

ASSIGNMENT OF BENEFITS

In certain circumstances, insurance companies may send a check for services provided by BETHEL KIDS DENTAL directly to the patient. In such cases, the patient agrees to endorse and send such a check to BETHEL KIDS DENTAL. If the patient deposits such a check into a personal account, the patient agrees to send a personal check for the equivalent amount to BETHEL KIDS DENTAL within 10 days of having deposited the check from the insurance carrier. INITIALS: _____

I hereby assign all dental benefits, to include major dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medi-cal Dental, private insurance and any other health/medical plan, to issue payment directly to BETHEL KIDS DENTAL. INITIALS: _____

FOR MEDI-CAL DENTAL INSURANCE PATIENTS

You are required to present a valid Benefit Issuance Card (BIC) at every visit and as needed. If you do not have a BIC card at the time of the visit, you are responsible to request a new or replacement card. If we do not have a valid BIC card or eligibility on file, you will be responsible for any fees that are left unpaid or not paid by Medi-Cal Dental. In the instance that Medi-Cal Dental has not paid within 90 days of filing the claim or paid less than anticipated for care, one of our team members will communicate with you regarding the situation. INITIALS: _____

I assume financial responsibility for all dental treatment and medications provided for my child. I understand that payment is expected on the date services are provided. I have read, understood, and agreed to the above financial policy for payments of rendered service(s) to our office.

Parent/Guardian Name: _____ Patient Name: _____

Parent/Guardian Signature: _____ Date: _____