Alameda DENTAL CARE
Healthy Smiles for a Lifetime

Child Information

Whom may we thank for referring you? _____

Name of Minor/Child_____ Birth date_____ Date _____
Sex M / F Age_____ Nickname_____School_____Grade_____
Home
Address_____
City_____State_____Zip_____ Home Phone_____

Parent or Guardian Information:
1) Name: _____ Home_____Work _____Cell_____
2) Name: _____ Home _____ Work _____Cell_____

Insurance Information
Father's/Guardians Name _____ Employer _____ Occupation_____
Address (if different from child) _____City _____State _____ Zip _____
Father's Birth date _____ Soc. Sec. # _____ Email _____

Mother's/Guardians Name _____ Employer _____ Occupation _____
Address (if different from child) _____City _____State _____ Zip _____
Mother's Birth date _____ Soc. Sec. # _____ Email _____

Do you have dental insurance for minor/child? Yes____ No ____ Policy holder_____
Company _____ Phone Number _____
Address _____City _____State _____Zip_____
Group #_____ Policy #_____

Child Dental History
Date of last dental visit _____ for what services? _____
Chief Dental Concern or Purpose for Today's Visit: _____

Has child complained about dental problems? **Yes** _____ **No** _____
Does child have any mouth habits- thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?
Yes _____ **No** _____
Please list_____
Does child brush teeth daily? **Yes** _____ **No** _____
Does child use floss every day? **Yes** _____ **No** _____
Is fluoride taken in any form? **Yes** _____ **No** _____
Any injuries to mouth, teeth, head? **Yes** _____ **No** _____
Has child experienced any unhappy dental visits? **Yes** _____ **No** _____

Please explain: _____

_____

_____

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Child Medical History

Child's Physician_____ City/State_____ Phone _____
Date of last physical examination_____ Results_____

Is your child under care of a physician now? **Yes** _____ **No** _____
Are Immunizations current? **Yes** _____ **No** _____
Is your child taking any medications? **Yes** _____ **No** _____
Please List_____
Is your child allergic to any medications? **Yes** _____ **No** _____
Please List: _____
Any Surgeries? **Yes** _____ **No** _____
Hospitalization **Yes** _____ **No** _____
Excessive bleeding when cut? **Yes** _____ **No** _____
Please describe: _____

Has child had any history of or difficulty with any of the following? *If yes please check if YES*:

A.I.D.S. / H.I.V.	_____	Anemia	_____	Asthma	_____		
Bladder problems	_____	Cancer	_____	Cerebral Palsy	_____	Chicken Pox	_____
Convulsions	_____	Diabetes	_____	Drug/ Alcohol Abuse	_____	Epilepsy	_____
Fainting	_____	Hearing Problems	_____	Hepatitis	_____	Kidney Disease	_____
Liver Disease	_____	Measles	_____	Mononucleosis	_____	Mumps	_____
Rheumatic Fever	_____	Sinus Problems	_____	Thyroid Problems	_____	Tuberculosis	_____

Other _____

In the case of an emergency, whom may we contact?

Name_____ Relationship _____ Phone _____

Minor/Child Consent

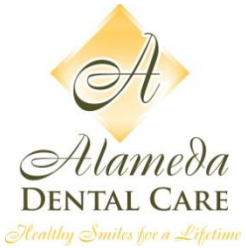
I am the parent, guardian, or personal representative of _____ and to the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by my insurance with _____and assign benefits, if any, to be directly paid to Alameda Dental Care for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named entity may use my child's health care information and may disclose such information to the above-name insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

Parent/Guardian signature_____Date_____

Print Parent/ Guardian name_____Relationship_____



ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

HIPAA. I acknowledge that I have received a copy of Alameda Dental Care Notice of Privacy Practices, containing a complete description of the uses and disclosures of my health information. This is simply an acknowledgement of receipt, and nothing more.

Patient Name _____
Relationship to Patient _____
Signature _____
Date _____

APPOINTMENTS AND FINANCIAL POLICY. I acknowledge that I have received a copy of Alameda Dental Care Appointments and Financial Policy. I have read, understand, and agree to the policy.

Signature of Responsible Party _____
Date _____

ASSIGNMENT OF BENEFIT. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. **I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Alameda Dental Care.**

Signature of Responsible Party _____
Date _____

OFFICE POLICY

Welcome to Alameda Dental Care! Our interest is to provide our patients with the finest possible dental care. As your provider, we advise treatment that is in the best interest of your medical and dental health. Be aware, often, insurance companies select the dental procedures that they will and will not cover without regard to your personal situation, health, and dental needs. Following is an overview of our office financial policy we provide to you as a courtesy.

Insurance: Dental Insurance rarely pays for 100% of all dental services. ***As a courtesy***, we will bill your dental insurance for your care, providing you give us the needed information for claim submission. Your estimated co-pays are due at time of service and any balance unpaid after the claim settles is due within 14 days of receipt of statement. Initials_____

Payment from the insurance company is expected within thirty (30) days. If your insurance company has not responded within a sixty (60) days grace period from the date of service, the remaining balance in full is your responsibility. At the time of service, we will request from you an initial payment; this is an estimated portion of the charges which insurance may not cover, including all applicable deductibles and co-pays. Initials_____

Copyright: Any comment posted online in any way relating to Alameda Dental Care, doctors or employees will be the sole right and property of Alameda Dental Care P.C. and the copyright of the content of the comment, rating, or review is hereby assigned to Alameda Dental Care P.C. to utilize at our discretion in order to protect the practice and our patient's anonymity and privacy. Initials_____

Payment: Payment in full is required at the time of service. For your convenience, we accept cash, checks, debit, and credit cards, including Visa, MasterCard, Discover, and American Express. Our office also offers No Interest and Extended Payment Plans, upon approved credit, through CareCredit. Initials_____

Estimates: Before treatment, we will perform a diagnosis and provide you with an estimate of the charges involved. As treatment progresses, it is possible that additional circumstances not be apparent at the initial exam, may be encountered. In this event, we will discuss options with you and proceed as necessary. Initials_____

Aged Account: The total balance on your account, after claim settlement, is due upon receipt of statement. Failure to keep this account current may result in Alameda Dental Care being unable to provide additional dental services. In the event of a default, I agree that any information collected can be used to collect on my account, and I agree to pay all costs incurred in the attempt to collect on this account, including late fees of 10% or $30 (whichever is greater), finance charges, service and/or collection agency fees, attorney's fees and court costs. Initials_____

Appointments: If you are unable to keep a scheduled appointment, we ask that you provide us with 48 hours notice as a courtesy. Notice of less than 48 hours may result in a minimum charge of $50.00 per hour. Initials_____

Assignment of Benefit: I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Alameda Dental Care.

I have read, understand, and agree to the above.

_____
Signature of Person Responsible for Account

_____ _____
Printed Name of Person Responsible for Account Date