Welcome!

We are pleased to welcome you to our pratice. Please fill out this form completely.
Do not hesitate to ask us if you have any questions.

CONFIDENTIAL PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	M/F
Street Address:	City:	State:	Zip:
Home Phone:	Birth date:	Social Security #:	
Child prefers to be called:			

CONFIDENTIAL RESPONSIBLE PARTY INFORMATION

Parent/Guardian Last Name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status(circle one) Single/ Mar/ Div/ Sep/ Other
Home Phone#:	Work Phone#:	Cell Phone#:	Birth date:	Relationship to patient:
Street address: (if different from above)		Social Security #:	E-mail address:	
P.O. Box:	City:	State:	ZIP Code:	
Occupation:	Employer:	Employer Address:	Employer Phone#:	
Parent/Guardian Last Name:	First:	Middle:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms.	Marital status(circle one) Single/ Mar/ Div/ Sep/ Other
Home Phone#:	Work Phone#:	Cell Phone#:	Birth date:	Relationship to patient:
Address: (if different from above)		Social Security #:	E-mail address:(if different from above)	
Occupation:	Employer:	Employer Address:	Employer Phone#:	

Who can we thank for referring you to our office? (please check applicable boxes if more than one source)

- ☐ Referrred by another office (name):
- ☐
- ☐ Friend (name):
- ☐ Family (name):
- ☐ Location:
- ☐

CONFIDENTIAL INSURANCE INFORMATION

Is this patient covered by insurance? ☐ Y ☐ N		if yes, does this patient have dual coverage? ☐ Y ☐ N	
Name of primary insurance:	Insurance Company Address:		Insurance Co. Phone#:
Subscriber's Name:	Subscriber's ID:	Brith Date:	Group #:
Patient's relationship to subscriber Child ☐ Other ☐			
Name of Secondary insurance:	Insurance Company Address:		Insurance Co. Phone#:
Subscriber's Name:	Subscriber's ID:	Brith Date:	Group #:
Patient's relationship to subscriber Child ☐ Other ☐			

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone #:

EMAIL CONSENT - I understand I can change my consent at anytime.

☐ I consent and accept the risk in receiving information via email. I consent to receiving appointment reminders via email or text.

☐ I do not consent receiving any information via email.

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. I also authorize Santa Margarita Pediatric Dentistry and my insurance company to release any information required to process my claims.

Parent/Guardian Signature: Date:

Santa Margarita Pediatric Dentistry 29941 Aventura Ste. C Rancho Santa Margarita CA 92688

Phone# (949)858-5150 Fax#(949)858-4714

Patient Health History

Child's Name: Last:	Birth date:
Child's Physician:	
Date of last physical exam:	
Is child under care of physican now? Y N	
Receiving any medications or drugs? Y N	
Ever been hospitalized? Y N	
Ever had surgery? Y N	

Has child had any history or difficulty with the following? Please circle Yes or No.

Y N A.I.D.S/HIV	Y N Cerebral Palsy	Y N Hay Fever	Y N Mental Disability
Y N Anemia	Y N Cleft Lip/Palate	Y N Hearing Problems	Y N Rheumatic Fever
Y N Bladder Problems	Y N Convulsions	Y N Heart Problems	Y N Sinus Problems
Y N Blood transfusion	Y N Developmental Disability	Y N Hepatitis	Y N Thyroid Disease
Y N Bruise Easily	Y N Diatetes	Y N Jaundice	Y N Tuberculosis
Y N Cancer	Y N Epilepsy	Y N Kidney Disease	Y N Premature
Y N Skeletal problems	Y N Fainting	Y N Liver Disease	Other

Any medications taken?	Has child ever had any asthmatic attacks? Y N If yes, Mild Moderate Severe Frequency?

Comments:

Is child allergic to, or ever had an adverse reaction to the following? Please circle Yes or No.

Y N Penicillin	Y N Sedatives	Y N General Anthesthesia
Y N Amoxicillin	Y N Sulfa Drugs	Other: (please list)
Y N Local Anesthetics	Y N Latex	

Dental History

Is this your child's fist visit to a dental office? Y N If no, please complete the following:

Name of previous dentist:	Phone #
Date of last visit to dentist:	Services received:

Please (circle) Yes or No to the following questions.

Has your child had any trouble associated with any previous dental treatment?	Y N	Sensitivity to hot/cold, sweet/sour	Y N
Have you been satisfied with your child's previous dental care?	Y N	Is flouride taken in any form?	Y N
Does child brush daily?	Y N	Does child suck his/her thumb?	Y N
Does child floss daily	Y N	Does child use a pacifier or bottle?	Y N
Do gums bleed while brushing or flossing?	Y N	Had orthodontic work?	Y N
Bite lips, cheeks, or nails?	Y N	Experience pain in any teeth?	Y N

The information that I have given is correct to the best of my knowledge. I understand that it will be held the strictest of confidence, and it is my responsibility to inform this office of any changes to my child's medical status. I also understand the use of anesthetic agents embodies a certain risk. I authorize Dr. Jeanne Nguyen and associates to perform all treatment for my above named child and consent to perform the necessary dental services for my child. ***I understand that I am financially responsible for all charges whether paid or not by insurance***. I also understand that responsibility for payment for dental services provided in this office for my child is mine, due and payable at the time services are rendered unless financial arragements have been made IN ADVANCE. I hereby authorize the dentist to release all infromation necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any charges in my child's insurance coverage.

SIGNATURE **DATE**

SANTA MARGARITA
PEDIATRIC DENTISTRY

Financial Policy

I voluntarily and knowingly request and consent to the services, treatments and/or procedures recommended by the dentist and to all diagnostic methods deemed appropriate by the dentist which may include, but not be limited to, x-rays, study models, imagery, and other aids. I authorize the dentist to perform all such services, treatment and/or procedures and to utilize all such diagnostic methods. Further, I acknowledge and understand that the dentist may engage the assistance of others in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.

I understand that the practice of dentistry is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.

I understand and acknowledge that I am fully and completely responsible for the payment of all costs associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage or managed care benefit that I may have is based on a contract between my insurance company or managed care company and me, my spouse and/or my employer. The dentist is not a party to this contract and the services, treatments, procedures and/or diagnostic methods are provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me. As a courtesy to me, the dental office will bill my insurance company or managed care company and I acknowledge that I will remain liable for any and all amounts not paid by the insurance company or managed care company for any reason (including but not limited to the insurance company or managed care company declining coverage after initially approving it) or if the insurance company or managed care company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or managed care information and any changes thereto.

All returned checks will be subject to a $25 returned check fee. In the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I consent to the dentist's use and disclosure of my health information to my insurance company or managed care company and any agent thereof. I hereby assign to the dentist all of the insurance and managed care benefits due to me for the services, treatments, procedures and/or diagnostic methods provided to me and I authorize my insurance company and/or managed care company to make payment directly to the dentist for the costs associated therewith.

I further consent to be contacted by the dentist, and agent of the dental office, or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred by mail at any address that I provide to the dental office and/or by facsimile, email or phone number (whether a cell phone or landline) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.

Patient:_____ Date:_____

Print Name:_____

Guardian/Responsible Party, if minor:_____ Date:_____

Print Name:_____