Happy Kids Pediatric Dentistry

Dr. Cruz Maria Ceino "Where Magical Smiles Begin"

Patient Information

Patient Name: _____ _____ Date: _____
Nickname: _____ Date of Birth: _____ Sex Male or Female
Home Address: _____
City: _____ State: _____ Zip Code: _____
Phone: _____ Social Security #: _____
How did you hear about us: _____
Reason for today's visit: _____

Mother's Information

Name: _____ Date of Birth: _____
Employer: _____ Social Security #: _____
Work Phone: _____ Home Phone: _____ Mobile: _____
E-Mail Address: _____

Father's Information

Name: _____ Date of Birth: _____
Employer: _____ Social Security #: _____
Work Phone: _____ Home Phone: _____ Mobile: _____
E-Mail Address: _____

Person Financially Responsible for Account

Name: _____ Date of Birth: _____
Employer: _____ Social Security #: _____
Work Phone: _____ Home Phone: _____ Mobile: _____
E-Mail Address: _____

Insurance Information

Dental Insurance Company: _____ Phone: _____
Name of Insured: _____ DOB: _____
Social Security Number of Insured: _____

Health Information

Y or N Has your child ever been hospitalized? If yes, please describe when and why:

_____

Y or N Has your child ever been treated in an emergency room? If yes, explain:

_____

Y or N Has your child ever had surgery? If yes, explain:

_____

Y or N Does your child need premedication with antibiotic before dental treatment?
Please list all current medications this patient is taking and include reason for taking_____

_____

Please list any known allergies: _____
Has your child ever been diagnosed with or treated for the following?

Yes **No** ADHD/Hyperactivity
Yes **No** Artificial Joints
Yes **No** Birth Defects
Yes **No** Breathing Problems
Yes **No** Developmental Delay
Yes **No** Heart Murmur
Yes **No** Kidney Disease
Yes **No** Liver Disease
Yes **No** Mental/Nervous Disorder
Yes **No** Premature Birth
Yes **No** Seizures/Epilepsy
Yes **No** Sickle Cell Disease
Yes **No** Tuberculosis
Yes **No** Anemia
Yes **No** Asthma
Yes **No** Cancer/Tumor
Yes **No** Delayed Speech
Yes **No** Fainting Spells
Yes **No** Diabetes
Yes **No** Sinus Problems
Yes **No** Low Birth Weight

If other please specify:

_____
_____
_____

When was your child's last dental visit: _____
Why did you leave the previous dentist: _____
Yes No Do you have any concerns regarding his/her teeth?

Yes **No** Do you supervise your child in brushing his/her teeth?

Yes **No** Does your child has any jaw/muscle discomfort?

Yes **No** Does your child drink bottled, high filtered or well water?

Yes **No** Does your child has click, pop, or other noise in the jaw joint?

Yes **No** Does your child frequently eat sweets and or drink juices or soda?

Yes **No** Are any teeth uncomfortable when chewing?

Yes **No** Does your child's gums bleed when brushing?

Yes **No** Does your child has any history of an accident/injury involving teeth?

Yes **No** Does your child have history of snoring or mouth breathing?

Yes **No** Does your child suck their thumb or a pacifier?

Yes **No** Does your child has a history of going to sleep with a bottle?

Yes **No** Does your child use fluoride toothpaste, tablets or rinses?

Yes **No** Does your child clench or grind his/her teeth?

Yes **No** Does your child teeth have sensitivity to cold or hot?

Yes **No** Does your child reacts well to dental procedures?

I, the undersigned parent/legal guardian of this child, certify that the above is accurate and complete to the best of my knowledge. I will notify Dr. Ceino and/or the staff of any changes in the above prior to appointment.

Signature: _____ Name: _____

Date: _____ Relationship to Patient: _____

Appointment Policy

We reserve your appointment time specifically for you. If you need to reschedule please give us at least 48 hours notice not including weekends so that we may give someone else the opportunity to utilize that time. A fee will be charged for late cancellations and/or missed appointment depending on the length, $30 per 30 minutes.

Signature: _____ Date: _____

Consent for Dental Treatment

I, the undersigned parent/legal guardian, hereby give consent for Dr.Ceino and staff to examine this child, clean his/her teeth, perform all necessary dental treatment, administer local anesthetics, apply topical fluoride, take diagnostic radiographs, take clinical photographs and other records necessary for an accurate diagnosis for my child. I understand that dental treatment for children involves behavior guidance which may include the use of praise, explanation or demonstration of procedures and instruments, variable tone voices, mouth props, nitrous oxide, or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect the child from potential injury.

Signature: _____ Date: _____

Financial Policy

This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you and not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from the date of service, you will be expected to pay the balance in full. As a courtesy to you we will help you process all your insurance claims. In order for our office to file your insurance claim, you must bring a complete dental insurance form or proof of insurance at each appointment. Your estimated copayment for treatment which is the amount not covered by your insurance is due at the time of service is provided. Your co-payment may be adjusted after the time of service depending upon final reconciliation of insurance payment. Our office accepts cash, personal checks, Master Card, Visa, and Discover. Outside financing is available through Care Credit upon request and approval. Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month. Please do not hesitate to ask if you have any questions regarding this financial agreement.

Signature: _____ Date: _____

Notice of Privacy Practices: HIPPA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and health operation. We may disclose your child's information to a health care provider treating him/her via telephone, mail, or e-mail. You may give us written authorization to disclose health information for any purpose. This authorization may be revoked in writing. We need written permission before any health information is disclosed any caregivers besides the child's legal guardian. In the event of any 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 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 an appointment reminder/confirmation or treatment recommendation (such as voicemails, postcards, e-mails, or letters).

Appointment Reminders

We may e-mail you or leave a message with a person or an answering machine/voicemail to reconfirm appointments. These e-mails/messages will be of non-sensitive nature and will include the doctor's name and/or the practice name. You may inform us in writing if you prefer to not to have e-mails/messages of this nature left for you.

Please send appointments reminders and other information regarding this child's appointments to the following e-mail: _____

If you prefer via phone, please indicate the best phone number: _____

Patient Rights

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

Restriction: You have a 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 child's health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your child' privacy rights or disagree with a decision we made about access to your child's health information you may submit a written complaint to the U.S. Department of Health and Human Resources.

Signature: _____ Date: _____