WELCOME

1 About Your Child

Today's Date: ____/____/____ File #: _____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: _____

School: _____ Grade: _____

Child's Home Phone #:(_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

_____

2 Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/___

Insured's Employer: _____

3 Child's Family Information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

Mother's Name: _____
❑ STEP MOTHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
❑ STEP FATHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____)_____ (_____)_____ _____
HOME PHONE # WORK PHONE # EXT.

_____ ____/____/____ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long? _____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: _____ _____
RELATION TO CHILD

Billing Address: _____

_____
CITY STATE ZIP

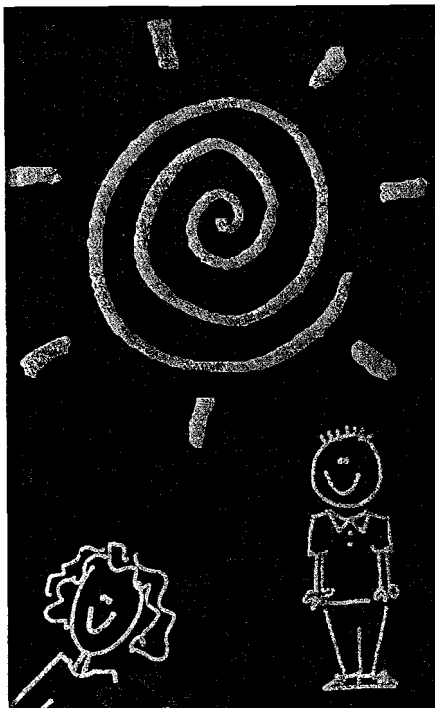
_____ ____/____/____ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____)_____ _____ (_____)_____
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ❑ Cash ❑ Check

_____ ____/____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials



5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw.	❑ Lost/Broken Filling(s)	❑ Stained teeth
❑ Red, swollen or bleeding gums.	❑ Teeth grinding	❑ Locking Jaw
❑ Sensitive tooth, teeth or gums.	❑ Ringing in Ears	❑ Bad breath
❑ Blisters/Sores in or around the mouth.	❑ Broken/Chipped tooth	❑ Loose tooth

❑ Other(s):_____

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist:_____ (____)_____

Last Dental exam: ____/____/____ Last Dental X-rays: ____/____/____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants ❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others:_____

Child's Physician:_____ (____)_____
DOCTOR'S NAME OR CLINIC NAME PHONE#

_____ Last Medical Exam: ____/____/____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or ever had:_____

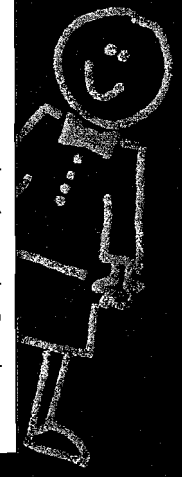
_____

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine) ❑ Aspirin ❑ Food allergies ❑ Other(s):_____

Please rate the child's general health from 1-10:_____ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long?_____ Child's Blood type:_____

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking ❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting



- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____/____/____
❑ Parent or Guardian ❑ Other:

UPDATE
(OFFICE USE)

Initials ____ Date ____/____/____

Comments

Initials ____ Date ____/____/____

Comments

Initials ____ Date ____/____/____

Comments

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient giving consent

Name of Patient: _____

Section B: To the Patient-please read the following statements carefully.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: Vanessa Todd - Office Manager at (562) 923-4538

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, **I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.**

_____ _____

Signature of Patient or Responsible Party Date Print Name of Patient or Responsible Party:

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

ONLY SIGN BELOW IF YOU WISH TO REVOKE YOUR CONSENT

Right to revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted in the reasons area below. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

Revocation of consent: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

Reason for revocation:

_____

_____

_____

Dental X-rays Avoiding Overexposure

Asking a dentist to work without x-rays, one says, is like asking an auto mechanic to find what's wrong with your engine without lifting the hood. X-rays provide a valuable way to detect and track dental disease

One source of unnecessary exposure: switching dentists. Generally, when you visit a new dentist, he or she will want to take a FMX, full-mouth series of images, a baseline from which to spot changes. Since a full-mouth series need be done only every 3 to 5 years, try to arrange for your previous dentist to send recent x-rays or duplicates.

Modern equipment, 'faster' film, and the lead apron used in dental offices all limit a patient's exposure to x-rays. The American dental association estimates that a full mouth series done with modern equipment exposes a patient to thirteen millirems of radiation. For comparison, the average person receives 300 millirems a year from natural environment, such as standing in front of your microwave, television and being exposed to sunlight, and workers whose occupation involves radiation are permitted 5000 millirems of whole body exposure a year.

We here at Dr. Duncker's we strongly suggest that new patients receive a current full-mouth set of x-rays or at minimum provide a recent set taken by a former dentist. After the initial exam each patient is individually assessed for the appropriate period between check-up x-rays. So remember when it comes to dentistry avoiding overexposure is important, but must be balanced with the calculated conservative recommendation of our trained dental team.

I understand the above information is necessary to provide me with dental care in a safe efficient manner.

Patient's Signature:**X** _____ Date: _____

MISSED APPOINTMENT FEE:

Your Dental plan contract specifies that a fee must be charged for failing to show for a regularly scheduled appointment. Our office policy is a $40.00 charge for each 30 minutes scheduled in our appointment book.

This policy specifies that if you do not give our office a 24-hour notice in advance of the appointment, your account will automatically be charged $40.00.

We are informing you that we cannot give credit, due to the fact that your plan is giving you a discount from the doctor's REGULAR FEE. You must pay for each visit, meaning each treatment.

I understand the above information and my signature below acknowledges my financial responsibility for any missed appointment. I hereby understand the above and agree to pay the services.

Signature:**X** _____ Date: _____