

747 Foothill Blvd. La Cañada, CA. 91011 Ph. (818) 790-1160 Fax (818) 790-5603 Email : dentistryforchildren@outlook.com

# **Child Health History**

Patient Name	Date of Birth
Welcome to our office. Please mark all appropricabild. Thank you.	iate health concerns pertaining to your
Please circle YES or No or fill in where appro	priate:
Purpose for today's visit	
Name of child's physician	
Physician's address	
Physician's phone number	
Date of child's last visit to physician	
DENTAL HISTORY	
Date of last dental examination	
Date of last dental X-rays	
Has the child had difficulties associated with professional of the child had difficulties associated with professional or the child had difficulties as the child had	,
Please indicate any of the items below that app	
	Yes/No
Oral habits: thumb sucking, nail biting	Yes/No
Frequent ulcers/blister	Yes/No
	Yes/No
Grinding of teeth	Yes/No
Bleeding gums	Yes/No
Recurrent/frequent headaches	Yes/No
Child still nursing	Yes/No
Breast/bottle	Yes/No
Please explain any of the above items	
checked	

### **MEDICAL HISTORY**

Has your child had any of the following medical conditions? Heart murmur......Yes/No Congenital Heart disease......Yes/No HIV Virus/Aids......Yes/No Blood Discover/Transfusion......Yes/No Sickle Cell Anemia.....Yes/No Hepatitis/Jaundice......Yes/No Tuberculosis......Yes/No Convulsion/Epilepsy......Yes/No Asthma......Yes/No Sinus problems......Yes/No Rheumatic Fever.......Yes/No Cancer/Tumors......Yes/No Kidney/Liver problems.....Yes/No Mental Handicap......Yes/No Physical Handicap......Yes/No Hearing Impairment......Yes/No Speech Impairment......Yes/No Hyperactive/ADHD......Yes/No Premature Birth......Yes/No Hospitalization......Yes/No Surgeries......Yes/No Explain any "YES" answers above or other problems not listed:\_\_\_\_ List any drugs the child is now taking List any drugs the child is allergic to\_\_\_\_\_ I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the doctor and staff to perform the necessary dental service to my child. Signature of patient/Guardian Date



# Dentistry For Children

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# **General Information for child**

Child's Name:	Nickname:			
Sex: MF Date of Birt	Nickname: h:/Age:			
	t this Office: Yes ( ) No( )			
9	Nickname:			
Sex: MF Date of Birt	h:/ Age:	<del></del>		
*How were you referred to our	office ?			
Home Address:_		City:	State:	Zip
Code:				
Home Phone# ( )	Email Adress:			
Emergency Contact:	Relationship:	Phone# (	)	
Dougan Dognandible for Chi	ld/Dationt's Appoint to Dist		OVE IVEORIA	ELON
	ld/Patient's Account: IF DIFF			
Home Address	City Email Address	State	_Zip Code	
Home Phone# ( )	Email Address			
*Father –Parent (1): *Parent (1) Na: Birth//	) Married( ) Seperated( ) Divorced( meExpiration Date	_SS#	Date	of
	Employer			
Work Address		ork Phone# ( )	-	
Parent (2)-Gurdian/Step paren		,		
Parent (2) Name	SS#	Date of Birth	/ /	
	Expiration Date			
	Employer		,	
Work Address	W	ork Phone# ( )_	<del>-</del>	
*Mother –Parent (1):				
	me	SS#	Date	of
Birth / /				
*Parent (1) Driver Licence #	Expiration Date	/ C	ell#( )	
*Parent (1) Occupation	Employer			
Work Address		ork Phone# ( )	<u> </u>	
Parent (2) – Guardian/Step par		` ,		_
Parent (2) Name		Date of Bir	th/	
Parent (2) Driver Licence #	Expiration Date	_// Cell#(	)	



Secondary Insurance -Insurance Name&Address:

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Parent (2) Occupation	Employer
Work Address	Work Phone# ( )
*Insurance and sign Insurance Information:	ature on reverse side:
( Please complete if your child has dental co	overage)
<u>Primary Insurance</u> - Insurance Name & Address:	

Subscriber ID#\_\_\_\_\_Group or Policy#\_\_\_\_

Subscriber ID#\_\_\_\_\_ Group or Policy#\_\_\_\_\_

I hearby certify that the foregoing information is true and correct. The undersigned, hereby authorizes the release of any information relating to all claim of benefits submitted on behalf of myself and/ or dependents. I further agree and acknowledge that my signature on this document authorizes my dentist and his staff to submit claims for benefits, for services rendered without obtaining my signature on each and every claim submitted for myself and/ or my dependents, and that I will be bound by this signature as though the undersigned has personally signed the particular claim until this authorization is revoked in writing. The undersigned accepts all finacial responsibility for all services rendered, including those not covered by insurance.

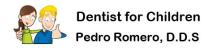
Authorize signature of Parent/Guardian (copies available upon request) \_Date\_\_\_/\_\_\_/\_\_\_ Signed

Subscriber Name\_\_\_\_\_

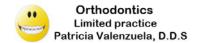
Subscriber Name:\_\_\_\_\_

Employer:\_\_\_\_\_

Employer\_\_\_\_\_







### OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for choosing Dr. Romero and Dr. Lezama for your oral health care needs. Our team's expertise, and commitment to our patients ensures you will receive the best comprehensive care possible. We hope to develop and maintain a professional relationship that will strengthen through the years to come. During this time we will establish a financial relationship. In order to successfully maintain this relationships it is important that you have a clear understanding of our office policies. Please read, understand, and sign this policy statement.

### **INSURANCE-**

We must emphasize that as dental health care providers, our relationship is with our patients, not the insurance companies. We are not part of your contract and cannot guarantee payments of all claims. If only a portion of your bill is paid by the insurance or a claim is rejected, any explanation will be provided to you by your insurance company. Reduction or rejection of your claim by your insurance does not relieve the patient of their financial obligations with the office. We are not responsible for how your insurance company processes claims, or what benefits are paid. For this reason we can only provide you with an "ESTIMATION OF YOUR INSURANCE COVERAGE AND BENEFITS". PPO insurance patient are required by your dental plan to pay all co-pays and deductibles at the time of visit. We do not balance bill payments owed to your home address. For your convenience we gladly accept Visa, Master card, Amex, Discover, Care Credit, Checks, and Cash payments

In order for us to bill your dental visit. You must submit Proof of current insurance coverage at the time of your reserved appointment. Without current proof of coverage, payment for your dental visit and all services will be required the day services are rendered. You may submit insurance information after the date of service, we will be glad to bill the insurance and refund your payment.

#### **CANCELLATIONS-**

A specific time is reserved when you schedule your appointment. We require patients to cancel appointments with at least 24 hour notice so we may reschedule the reserved time and offer this availability to another patient. We offer a one-time waived fee to our patients, as we understand that there may be personal conflict or illness. Any cancellations made after initial write off has been accessed, a broken appointment fee will automatically be applied to patients account. It is our policy to charge a fee of \$ 25.00 per account for any appointment that has been scheduled in advanced and cancelled with less than a 24 hour notice. Cancelation of appointments made on the same day must be done with at least an hour of notice or the broken appointment fee will apply. Our automated system is designed to help you keep organized with your future appointments. With the provided email on file we will send out a confirmation email (2 weeks) before your scheduled visit. If we do not receive any response from the email. You will then receive a text message from the provided cell phone on file. Again, if there is no correspondence from the text message reminder. We will call as a courtesy the night before the scheduled appointment. If the office is closed and you are requesting to cancel your appointment, please leave a message on our after-hours answering machine phone number (818-790-1160) so we may notate your account. Or you may email us at dentistryforchildren@outlook.com. The broken appointment fee will not be applied if your message, or email is left before the required 24 hour notice to your scheduled appointment.

#### PEADATRIC PATIENTS & SCHEDULING-

We do encourage our younger patients to schedule for our early morning availability. This allows Dr. Romero the time to dedicate all his attention to any concerns, anxieties, or fears of the child may have. All dental treatment diagnosed will be scheduled Wednesday through Friday from opening till 2 pm. As we are extremely busy with routine hygiene visits in the after school hours we are unable to schedule treatment from 3pm to closing. Your child's dental appointment is an excused absences from school, and we do provide our patients with a school absence note, and work excused letters.

### FINANCIAL REQUIREMENTS AND PAYMENTS FOR ALL PATIENTS-

- ❖ We have established the length of time that we will carry outstanding balances with our patients. Therefore, prior credit card payment authorization for unpaid balances beyond 90 days from the date of services is now required. All current covered insurance will be submitted first. We will bill the credit card on file for any charges that exceed the 90 day mark. A \$25.00 fee will be applied if credit card payment is declined for any reason. Please make sure that all credit card information given to the office remains valid at all times. Receipts for all charges made will be mailed to address on patients file.
- ❖ We are not in a position to mediate payment arrangements between separated parents or guardians. Any person accompanying the patient, or minor to the office will be financially responsible for any charges incurred. We do not balance bill payments to your home address. For your convenience we gladly accept Visa, Master card, Amex, Discover, Care Credit, Checks, and Cash payments.
- For our non-insurance patients a courtesy adjustment will be applied to treatment paid in full using cash only (excludes debit, and check) Details upon request.
- We request payment for first time appointments to the office be satisfied with cash, or by credit only. No checks will be accepted. We apologize if this causes any inconvenience. This is a short term arrangement.
- There will be a returned check fee of \$ 12.00 for any insufficient funds received by the office. This fee will be added to the outstanding balance of your account.
- We do understand that financial hardships can affect timely payment of your account. If problems do derive. Please contact once your first billing statement has been received. We offer Care Credit, with credit approval. If care credit is not an option. We can set up a financial agreement in house. This allows us to agree upon a comfortable payment arrangement to pay for overdue payments, treatment, or patient portions for services provided.

and Dr.Lezama's dental practice.	
(PRINT) name of Responsible Party:	Date:

By signing this agreement I acknowledge and understand the policies explained above pertaining to Dr. Romero