PEDRO A. ROMERO, D.D.S
MARCELA LEZAMA, D.D.S

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 appropriate health concerns pertaining to your child. Thank you.

Please circle YES or No or fill in where appropriate:

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 previous dental treatment?.....Yes/No
If so, explain_____
Please indicate any of the items below that apply to your child:
Injury to mouth/teeth.....Yes/No
Oral habits: thumb sucking, nail biting.....Yes/No
Frequent ulcers/blister.....Yes/No
Sensitive/painful teeth.....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
Diabetes……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.

X_____ _____

Signature of patient/Guardian Date

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General Information for child

Child's Name:_____Nickname:_____
Sex: M___F___ Date of Birth:_____/_____/_____ Age:_____
Other Children Being Treated at this Office: Yes ( ) No( )
Child's Name:_____Nickname:_____
Sex: M___F___ Date of Birth:_____/_____/_____ Age:_____

*How were you referred to our office ? _____

Home Address:_____City:_____State:_____Zip Code:_____
Home Phone# ( )_____-_____ Email Adress:_____
Emergency Contact:_____Relationship:_____Phone# ( )_____-_____

Person Responsible for Child/Patient's Account: ***IF DIFFERENT FROM ABOVE INFORMATION-***

Home Address_____City_____State_____Zip Code_____
Home Phone# ( )_____-_____ Email Address_____

Parent Information: ***Single ( ) Married( ) Seperated( ) Divorced( ) Widowed( ) Custody: Single( ) Dual( )***

****Father –Parent (1):***
*Parent (1) Name_____SS#_____-_____-_____Date of Birth____/____/_____
*Parent (1) Driver Licence #_____Expiration Date____/____/____ Cell#( )_____-_____
*Parent (1) Occupation_____Employer_____
Work Address_____Work Phone# ( )_____-_____
Parent (2)–Gurdian/Step parent/Conservator:
Parent (2) Name_____SS#_____-_____-_____Date of Birth____/____/_____
Parent (2) Driver Licence #_____Expiration Date____/____/____ Cell#( )_____-_____
Parent (2) Occupation_____Employer_____
Work Address_____Work Phone# ( )_____-_____

****Mother –Parent (1):***
*Parent (1) Name_____SS#_____-_____-_____Date of Birth____/____/_____
*Parent (1) Driver Licence #_____Expiration Date____/____/____ Cell#( )_____-_____
*Parent (1) Occupation_____Employer_____
Work Address_____Work Phone# ( )_____-_____
Parent (2) – Guardian/Step parent/Conservator:
Parent (2) Name_____SS#_____-_____-_____Date of Birth____/____/_____
Parent (2) Driver Licence #_____Expiration Date____/____/____ Cell#( )_____-_____

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Parent (2) Occupation_____Employer_____
Work Address_____Work Phone# ( )_____-_____

Insurance and signature on reverse side:

Insurance Information:

(Please complete if your child has dental coverage)

Primary Insurance -
Insurance Name & Address:

_____
Subscriber Name_____
Employer:_____
Subscriber ID#_____Group or Policy#_____

Secondary Insurance -
Insurance Name&Address:

_____
Subscriber Name:_____
Employer_____
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.

Signed_____Date____/_____/_____
Authorize signature of Parent/Guardian (copies available upon request)

Dentist for Children
Pedro Romero, D.D.S

General Dentist
Marcela Lezama, D.D.S

Orthodontics
Limited practice
Patricia Valenzuela, D.D.S

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.

By signing this agreement I acknowledge and understand the policies explained above pertaining to Dr. Romero and Dr.Lezama's dental practice.

(PRINT) name of Responsible Party: _____Date:_____