Smile Kingdom Dental
General Dentistry
For Infants, Children, and Teens
916-852-8510
www.smilekingdom.com

**Patient Name:** _____
**LAST** **FIRST** **MIDDLE**

**• Male • Female** **Date of Birth** _____ **Age:** _____

**How did you hear about our office?** _____

**BIO PARENT • STEP PARENT • GRANDPARENT • LEGAL GUARDIAN •**

**NAME:**_____ _____
**LAST** **FIRST** **DATE OF BIRTH**

**SOCIAL SECURITY NUMBER:** _____ **• MARRIED • SEPERATED • DIVORCED • SINGLE**

**HOME PHONE:** _____ **CELL PHONE:** _____**WORK:**_____

**HOME ADDRESS:** _____
**STREET** **CITY** **ZIP CODE**

**EMPLOYER:** _____ **OCCUPATION:** _____

**DENTAL INSURANCE:** _____ **ID: #** _____

**INSURANCE PHONE NUMBER:** _____ **GROUP #** _____

**EMAIL ADDRESS**: _____

**BIO PARENT • STEP PARENT • GRANDPARENT • LEGAL GUARDIAN •**

**NAME:**_____ _____
**LAST** **FIRST** **DATE OF BIRTH**

**SOCIAL SECURITY NUMBER:** _____ **• MARRIED • SEPERATED • DIVORCED • SINGLE**

**HOME PHONE:** _____ **CELL PHONE:** _____**WORK:**_____

**HOME ADDRESS:** _____
**STREET** **CITY** **ZIP CODE**

**EMPLOYER:** _____ **OCCUPATION:** _____

**DENTAL INSURANCE:** _____ **ID: #** _____

**INSURANCE PHONE NUMBER:** _____ **GROUP #** _____

**IF THERE IS A DIVORCE DECREE,** PLEASE SPECIFY WHO HAS FULL CUSTODY, OR, IF THERE IS A COURT ORDER IN WHICH ONE PARENT IS TO PROVIDE INSURANCE. THIS HELPS US DETERMINE WHO IS PRIMARY AND WHO IS SECONDARY: (CO PAYS ARE STILL DUE AT TIME OF SERVICE BY PERSON SIGNING THE TREATMENT PLAN)

**ASSIGNMENT AND RELEASE**: I hereby authorize the insurance benefits to be paid to the dentist. I also authorize the dentist to release any information required for all claims. I acknowledge that I am FINANCIALLLY RESPONSIBLE for all charges whether they are paid by the insurance. A minimum service charge of $1.00 (not to exceed 1%) on all charges over 90 days old will be accessed. If I desire credit to be extended to me and/or my family for services rendered, I am aware that a credit report may be obtained before credit is extended. In the event of default of payment and / or failure to pay, I agree to pay the cost of collection including court cost and reasonable attorney fees to be determined by a court of law. (I understand and agree that) any legal action arising under or related to this agreement, shall be brought and maintained exclusively in a state of court of Sacramento County, State of CA, and the parties hereby submit themselves to the personal jurisdiction, process or venue brought in those courts.

**SIGNED** _____ **DATE:** _____

## YOUR CHILD'S MEDICAL HISTORY:

**Patient Name:** _____
**LAST** **FIRST** **MIDDLE** **AGE**

## DENTAL INFORMATION

1. Is there a situation you would like to have examined today? Yes • No • **If yes, Please explain:** _____
2. When was your child's last dental cleaning and exam? _____
3. Has your child been seeing a dentist for examinations and preventative care? Yes • No •
4. Has your child had any negative experiences with dentist or doctors? Yes • No • **If yes, please explain :** _____
5. Is your child taking fluoride? Yes • No •

**Does your child have any of the dental habits or concerns listed below?**

Pain to Hot or Cold? Yes • No •
Problems with brushing or flossing Yes • No •
Cleft Lip / Palate Yes • No •
Grinding Yes • No •
Favors eating on one side? Yes • No •
Crowding? Yes • No •

Bubbles or swelling in the Gum area? Yes • No •
**IF YES: How long has he/she had this?** _____
**Any other concerns?** _____

## MEDICAL INFORMATION:

PLEASE BE AWARE THAT ALL MEDICAL CONDITIONS, ALLERIGES, AND RECENT SURGERIES PLAY A ROLE IN YOUR CHILD'S DENTAL HEALTH. THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US IN THE TREATMENT AND BETTER UNDERSTANDING OF YOUR CHILD. **PLEASE LIST ADDITIONAL CONDITIONS ON THE BACK OF THE PAGE IF NECESSARY.**

CHILD'S PHYSICIAN: _____ PHONE NUMBER: _____

HOSPITAL OR MEDICAL GROUP: _____ Last seen: _____

**Is your child allergic to any of the following? Please also mark all that apply below.**

- **Aspirin**
- **Penicillin or Amoxicillin**
- **Clindamycin**
- **Sulfa Drugs**
- **Latex**
- **Local Anesthetics**

1. HEART MURMUR, HEART DISEASE OR RHEUMATIC FEVER? **Yes • No •**
2. (If yes does your child need an antibiotic before any dental treatment or dental cleaning? **Yes • No •** **(**Documentation will be required)
3. High or low blood pressure? Yes • No •
4. Hay Fever or seasonal allergies? Yes • No •
5. Sinus Problems Yes • No •
6. Herpes or Cold Sores Yes • No •
7. Diabetes Yes • No •
8. Low Birth Weight/ Premature Yes • No •
9. Autism / Autism Spectrum Disorder Yes • No •
10. Cerebral Palsy Yes • No •
11. Down Syndrome Yes • No •
12. Anemia Yes • No •
13. Asthma Yes • No •
14. Spina Bifida Yes • No •
15. Kidney Disease Yes • No •
16. Cancer, Tumors, other Growths Yes • No •
17. Radiation or Chemotherapy Yes • No •
18. Immunologic deficiency disease Yes • No • (Leukemia, AIDS/HIV POSITIVE, Other)
19. Liver Disease (Hepatitis, Jaundice) Yes • No •
20. Thyroid Problems Yes • No •
21. Lung Disease Yes • No • (TB, Asthma, persistent cough, other)
22. Epilepsy, Seizures, fainting spells Yes • No •
23. Arthritis Yes • No •
24. Sore Throats, Tonsillitis, Earaches Yes • No •
25. Venereal disease Yes • No •
26. Abnormal bleeding/ blood disorders Yes • No •

IF yes, what: _____

27. Smoke or use tobacco Yes • No •
28. ADD or ADHD Yes • No •
29. Behavior and/or emotional problems Yes • No •
30. Is your child adopted? Yes • No •
31. Does he/she know? Yes • No •
32. Does your child receive regular vaccinations? Yes • No •
33. Is your child taking any drugs or medications, prescription or non-prescription? Yes • No •

If yes: please list: _____

34. Has your child been treated or currently being treated for any chemical dependency? Yes • No •

If your child is of age, is there any possibility your child could be pregnant? Yes • No • Does she take birth control? Yes • No •

**PARENT'S SIGNATURE:** **DATE:**

# Smile Kingdom Dental Financial and Office Policies

**_____ Financial Policy:**

Initial

- **IT IS OUR POLICY TO RECEIVE PAYMENT AT THE TIME OF SERVICE, AND IT IS DUE AT CHECK-IN.** For your convenience we accept cash, money orders, and most credit cards payments, including Care Credit at the time of service. We will ask for ID before using these forms of payments. In the event of a divorce, the responsible party is the parent that brings the child to the appointment, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties, as we will not intervene. **Please also be advised, that in the event that we may have to send your account to collections, a $35.00 late fee will be applied to the balance.**
-

**_____ Estimates:**

Initial

- **As a courtesy, we will give you an ESTIMATE for your portion based on the information given to us by your insurance carrier. Please remember that this is only an estimate**, and if any additional co-payments occur after insurance pays, that it will also be your responsibility. Treatment plans may change based on the needs of your child, but we will always do our best to provide you with an estimate as anything changes. For extensive treatment, a preauthorization will be submitted to your insurance. The preauthorization can take up to 4 weeks to process and is not a guarantee of insurance payment.

**_____ Insurance**

Initial

- **As a courtesy, we are happy to file a dental claim with your insurer on your behalf, but YOU are ultimately responsible for all charges.** We are happy to submit the claims necessary to see that you receive the full benefits of your coverage, however we cannot guarantee any estimated coverage, or insurance payments. We ask that you read through your policy so that you are fully aware of the benefits provided and the limitations imposed. Though we do our best to keep up with any changes with your insurance, we ask that you let us know if there are any changes to your policy as you will be responsible for any patient portions that occur. If your insurance delays payments (after 90 days of submission), then you will also be responsible for the balance.

**_____ No Shows or Cancellations**

Initial

- **We require at least 2 BUSINESS DAYS NOTICE** if your child is not able to come to their appointment. After 2 cancellation/No Show, we will ask **deposits to schedule future appointments**. Our cancellation policy is as follows:
  - ✓ There will be a **NON-REFUNDABLE deposit / charge of $50.00** to your account for every cleaning appointment missed without 2 business days notice**.**
  - ✓ **It is a NON-REFUNDABLE deposit/charge of $75.00 for Treatment appointments or Saturday appointments**. If a Saturday appointment is missed it will not be offered to your family again until appointment history improves.
  - ✓ If we find that cancellations / No Shows are excessive we will retain the right to dismiss your family from the practice, and we will give you 30 days to find another dentist.

**_____ Treatment Policy**

Initial

- For your comfort, one adult is welcome, but not required, to accompany your child to the operatory. When accompanying the child during treatment we ask that you be a "silent partner" so that we may focus on establishing a relationship, and to build trust with the child. The person accompanying the child must remain in the office at all times while the child is in our office. If you are unable to accompany your child on the subsequent appointments, a form entitled "Authorization for others to consent to dental care" must be filled out by the parent. All Co pays are still due at the time of service even with this form. We ask that you don't take photographs, or video, for the reason that it can be distracting during treatment.

**Release of Liability and Assumption of risk – I acknowledge that enjoyment of various play activates at Smile Kingdom Dental is based upon my, as the parent or guardian of minor, executing this Release of Liability and Assumption of Risk.** I hereby understand and agree to assume all risks and dangers to my child or minor, such as falling down off of equipment, whether or not listed herein. I understand that as the guardian of the minor I am choosing to bring into Smile Kingdom Dental, that the well-being of the minor is fully my responsibility. Additionally, I hereby release and waive on behalf of my child and, if applicable, my minor ward, to the extent permitted by law, all claims or causes of action against Smile Kingdom Dental, and all of their affiliates, including Officers, Doctors, directors, employees, contractors, agents, hairs, and assigns. By signing this document, I acknowledge that I have read and understand the provisions contained herein.

_____ _____

**Parent / Guardian Signature** **Date**

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# Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA)

I certify that I have received a copy of Jose V. Juarez, D.D.S. Inc. Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my child(ren)'s protected health information (PHI) that might occur in his/her treatment, payment for services or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and Jose V. Juarez, D.D.S. Inc. duties with respect to my child(ren)'s protected health information. The Notice of Privacy Practices is posted in the facility.

Jose V. Juarez, D.D.S. Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices at the time of my child(ren)'s first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

**ADDITIONAL DISCLOSURE AUTHORITY**

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my child(ren)'s protected health care information (PHI) to the person's indicated below.

| | | | | |
|---|---|---|---|---|
| My child(ren)'s other parent / step-parent / sibling | | YES | | NO |
| Grandparent or other child care provider | | YES | | NO |
| Other (Please write name and relation) | | YES | | NO |

_____ _____

Name of patient(s) Signature of parent/ guardian responsible for patient(s)

_____ _____

Date Relationship or personal representative to patient

*OFFICE USE ONLY BELOW THIS LINE*

| RECORD OF ACKNOWLEDGEMENT NOT OBTAINED | | | | |
|---|---|---|---|---|
| PROVIDED PRIOR TO TREATMENT? | | YES | | NO |

IF YES: DATE IT WAS PROVIDED: _____

**REASON FOR DENIAL?**

| | |
|---|---|
| | NEEDED MORE TIME TO REVIEW NOTICE OF PRIVACY PRACTICES |
| | WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING |
| | UNABLE TO SIGN |
| | OTHER ( EXPLAIN) |