NEWPORT PEDIATRIC DENTISTRY

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PATIENT INFORMATION

Please use black ink only

Patient's Name _____ Nickname _____ Sex: M / F
First Middle Last
D.O.B. _____ / _____ / _____ Age _____ Height _____ Weight _____lbs
Name of School _____ City_____ Grade _____

RESPONSIBLE PARTIES

MOM's Name _____ Marital Status: M / D / S / W D.O.B. ____/____/____
Address _____ City_____ Zip Code _____
Home Phone (____) _____ - _____ Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____
Social Security # _____-_____-_____ Driver's License # _____ State _____
DAD's Name _____ Marital Status: M / D / S / W D.O.B. ____/____/____
Home Phone (____) _____ - _____ Cell Phone (_____) _____-_____ Work Phone (_____) _____-_____
Address _____ City_____ Zip Code _____
Social Security # _____-_____-_____ Driver's License # _____ State _____

❑ I consent to the dental practice using my cell phone number and/or email to ❑ call ❑ text ❑ email regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____ email: _____ _____ **(initial)**

DENTAL INSURANCE INFORMATION

Name of Insurance Company _____ Subscriber's Name _____
Relationship _____ Group # _____ D.O.B. _____ / _____ / _____ SSN _____ / ____ / _____
Name of Employer _____ Occupation _____

MEDICAL HISTORY

Please answer the following questions as thoroughly as possible and circle the appropriate responses.
Describe your child's overall physical health Excellent / Good / Fair / Poor
Name of child's pediatrician _____ City _____ Phone # (____) ____ - ____
Is your child currently under the care of a physician? Y / N
If so, please describe _____
Has your child had any serious illness or injury? Y / N
If so, please describe (include age) _____
Is your child current on all vaccinations? Y /N

Has your child ever had any of the following? **CIRCLE YES OR NO**

Abnormal Bleeding	Y / N	Learning Disabilities	Y / N	Measles	Y / N	Tuberculosis	Y / N
AIDS/HIV	Y / N	Mental Disabilities	Y / N	**Mitral Valve Prolapse**	Y / N	Sinus Problems	Y / N
Anemia	Y / N	Physical Disabilities	Y / N	Mononucleosis	Y / N	Shortness of Breath	Y / N
Asthma	Y / N	**Heart Murmur**	Y / N	Scarlet Fever	Y / N	Fainting Spells	Y / N
Blood Transfusion	Y / N	Hemophilia	Y / N	Seizures	Y / N	Thyroid Problems	Y / N
Blood Pressure	Y / N	Hepatitis	Y / N	Sickle Cell Anemia	Y / N	Bone Disorders	Y / N
Diabetes	Y / N	Kidney Problems	Y / N	Tonsillitis	Y / N	Growth Problems	Y / N
Epilepsy	Y / N	Lupus	Y / N	Rheumatic Fever	Y / N	**Heart Defect**	Y / N
Hives	Y / N	Liver Problems	Y / N	Hearing Impairment	Y / N	Cancer	Y / N

PATIENT'S NAME_____

Does your child have any disease, condition or problem not listed above that you think we should know about? Y / N
If so, please describe_____
Please list **ALL medications** your child is currently taking_____
Please list **ALL allergies** your child has, including to medication_____
Does your child have an allergy to **LATEX?** Yes / No Does your child have an allergy to **PENICILLIN?** Yes / No

DENTAL HISTORY

Please answer the following questions as thoroughly as possible and circle the appropriate responses.

1. How did you hear about our office?_____
2. Is this your child's first dental visit?
   Date of Last Dental Exam: ____/____/____ N/A Date of Last Cleaning: ____/____/____
3. What is your reason for bringing your child to the dentist today? _____
4. Has your child experienced any problems with previous dental work? Y / N
   If so, please explain _____
5. Is your child nervous or frightened about dental visits? Yes / Somewhat / No / This is our 1st Visit
6. Have there been any injuries to your child's teeth, jaw or chin? Y / N
   If so, please explain _____
7. Does your child take fluoride supplements or drink **fluoridated water**? Y / N
8. Has your child ever been seen by an orthodontist? Y / N
   If so, who _____ When _____ Where _____
9. Does your child brush his/her teeth daily? Y / N
10. Does your child floss his/her teeth daily? Y / N
11. Does your child have any of the following? **Please circle each answer**

Sleep Apnea	Y / N	Clenching	Y / N	Speech Problems	Y / N
Thumb/Finger/Lip Sucking	Y / N	Chewing on Objects	Y / N	Mouth-breathing	Y / N
Nursing Bottle Habits	Y / N	Tongue Thrust	Y / N	Grinding	Y / N
Pacifier Sucking Habits	Y / N	Snoring	Y / N	Nail Biting	Y / N

Cancellation Policy: We make every effort to accommodate the busy schedules of our patients and their families. If you are unable to attend your appointment for any reason, we require that you notify our office **AT LEAST 24 HOURS** in advance. If you do not notify us 24 hours in advance, you will be charged a $50 fee. (**Initials**) _____

I certify that the provided information is true and correct to the best of my knowledge. I agree to notify you about any changes in my child's health status or the above information. I acknowledge receipt of this office's Notice of Privacy Practices **(HIPPA)** and dental materials fact sheet. Furthermore, I understand that Newport Pediatric Dentistry will release our private information ONLY to other previously authorized individuals and insurance providers.

Responsible Party Signature_____ Date_____

I assume financial responsibility for the above named child. I understand that payment is due on the day services are rendered. I authorize Newport Pediatric Dentistry to collect payment from the insurance company. I understand that the insurance company may pay only a portion of my bill and that ultimately I am responsible for the full payment. When benefits are assigned directly to this office, if the insurance company sends a check to you in error, we will hold you responsible for immediate and complete reimbursement. If the insurance company has not paid the entire benefit available, we will hold you directly responsible for payment of the outstanding amount. At any point during treatment, if the insurance company becomes uncooperative, we reserve the right to refuse to work with that insurance company and will look to you for payment of the remaining balance and you will have to settle with your insurance company.

Responsible Party Signature_____ Date_____

Doctor's Signature_____ Date_____

NEWPORT PEDIATRIC DENTISTRY

INFORMED CONSENT FOR TREATMENT

1.) I hereby authorize Dr. Christian Lopez to take x-rays, study models, take photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I also authorize Dr. Lopez to perform all recommended and mutually agreed upon treatment, and to use the appropriate medication and therapy in connection with such treatment.

2.) I certify that my child is covered by _____Insurance Co. and I assign all insurance benefits directly to Dr. Lopez. I understand that I am responsible for payment of all services rendered and am also responsible for paying co-payments and deductibles that my insurance does not cover. I hereby authorize Dr. Lopez to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

3.) I understand it is my responsibility to advise your office of any changes in the information contained on these forms.

4.) If I have dental insurance, I understand that all deductibles, co-payments, and portions of my bill that insurance does not cover are due at the time of service. If I do not have dental insurance, payment of all services are due at the time of service.

5.) You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

Informed consent indicates your awareness of, and agreement to, the various procedures performed at Newport Pediatric Dentistry. You understand that you have the right to ask any questions and we have the obligation to provide you with appropriate answers. It is our intent to provide the best possible dentistry for your child. We will always use warmth, friendliness, persuasion, humor and kindness. There are several other common behavior management techniques that are used by the dentist to protect the safety of your child, to eliminate disruptive behavior and to prevent the child from causing injury to themselves or others due to uncontrolled movements. The following are the techniques commonly used in our practice to sooth and calm an uncooperative patient:

Tell-Show-Do: The dentist and assistant explain to the child what will be done. We use simple terminology and repetition followed by a demonstration with instruments of what is to be done. The procedure will then be attempted on the child's mouth. Praise is used to reinforce cooperative behaviors.

Positive Reinforcement: These are techniques we use to reward the child for displaying desirable and cooperative behavior. Rewards may include praise, compliments, high-fives, prizes, or stickers.

I hereby acknowledge that I have read and that I understand the consent form. I hereby give authorization and consent to utilize the above techniques listed in conjunction with the treatment listed on my child's treatment plan.

_____ _____

Patient's Name Responsible Party Name

_____ _____ _____

Relationship to Patient Responsible Party Signature Date

NEWPORT PEDIATRIC DENTISTRY

CONSENT TO TREAT MINORS

I (We) the undersigned parent, parents, or legal guardian of_____ DOB ___/___/___, a minor, do hereby authorize and consent to any x-ray, examination, anesthetic, dental diagnosis, and performance of all recommended treatment which is deemed advisable by and is to be rendered under the general or special supervision of any dentist of Newport Pediatric Dentistry. It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority and power to render care which the aforementioned dentists in the exercise of their best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but any of the above treatments will not be withheld if the undersigned cannot be reached.

I (we) understand the importance of my (our) presence during appointments, but in the case of my (our) unavoidable absence, I (we) give permission for the following person(s) to provide necessary supervision:

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I (we) acknowledge that it is my (our) responsibility to immediately notify Newport Pediatric Dentistry of any changes to the above information.

_____ ___/___/___ _____
Signature of Legal Guardian Date Relationship to Patient

_____ ___/___/___ _____
Signature of Legal Guardian Date Relationship to Patient

Please note Newport Pediatric Dentistry may require copies of legal guardianship papers, if applicable. Please know that all payments are due at the time of service. If you have dental insurance, deductibles, co-payments, and portions of your bill that insurance does not cover are due at the time of service.

Our Office Policy Regarding Dental Insurance

If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits, as we will collect from you the estimated amount insurance is not expected to pay. By law your insurance company is required to pay each claim within 30 days of receipt. We bill all insurance electronically so your insurance company will receive each claim within days of the treatment. You are responsible for any balance on your account after 30 days whether insurance has paid or not.

Your insurance is a contract between you and your insurance company. **It is your responsibility to know your own coverage.** We encourage you to call your insurance company and understand your policy. As a courtesy, we will bill your insurance. The patient pays the estimated portion (as calculated by our practice) at the time of the service. Any estimate given to you by our practice is purely **"an estimate."** The insurance companies do not guarantee any payment until they receive the claim, review it and process it according to the specific plan allowable, deductibles and co-pays. If there is a balance after the claim is billed and insurance payment is received a bill will be generated and sent to the patient for immediate payment. If the claim has not been paid in 30 days, we require you to pay the balance.

Insurance Facts

Fact 1 –No Insurance Pays 100% Of All Procedures

Dental insurance is meant to be an aid in receiving dental care. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay 50%-80% of the average total fee. Some pay more, some pay less. The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company.

Fact 2 –Benefits Are Not Determined By Our Office

You may have noticed that sometimes your dental insurance reimburses you or the dentist at a lower rate than the dentist's actual fee. Frequently, insurance companies state that the reimbursement was reduced because your dentist's fee has exceeded the usual, customary, or reasonable fee ("UCR") used by the company.

A statement such as this gives the impression that any fee greater than the amount paid by the insurance company is unreasonable or well above what most dentists in the area charge for a certain service.This can be very misleading and simply is not accurate.

Insurance companies set their own schedules and each company uses a different set of fees they consider allowable. These allowable fees may vary widely because each company collects fee information from claims it processes. The insurance company then takes this data and arbitrarily chooses a level they call the "allowable" UCR Fee. Frequently this data can be three to five years old and these "allowable" fees are set by the insurance company so they can make a net 20%-30% profit. Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary, or reasonable (UCR) figure.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

I have read and understand the terms and conditions.

Responsible Party _____

Date _____