ANDREW YAP DR. D.D.S. family & cosmetic dentistry

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NEW PATIENT INFORMATION – CHILD

Child's Name(FIRST MI. LAST): _____ Preferred to be called: _____

Birth Date: _____/_____/_____ Age: _____ SSN # _____ Sex : ☐ Male ☐ Female

School Currently Attending: _____ Grade Level _____

WHOM MAY WE THANK FOR REFERRING YOU? Name: _____

PARENT INFORMATION

Marital status of parents: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

IF PARENT IS PATIENT OF THIS OFFICE ☑
Name of Parent or Legal Guardian ☐ _____ Relationship to patient: _____

Address: _____ City: _____State:_____ Zip:_____

Home Telephone #:(_____)_____ Work #:(_____)_____ Cell#:(_____)_____

Birth Date: _____/_____/_____ SS#:_____Email Address: _____

Occupation: _____ Employer: _____Dept:_____

Employer's Address _____ City: _____State:_____ Zip:_____

DENTAL INSURANCE: Is child covered by this parent's insurance? Y N

Insurance Plan Name: _____ID#:_____ Group #:_____

IF PARENT IS PATIENT OF THIS OFFICE ☑
Name of Parent or Legal Guardian ☐ _____ Relationship to patient: _____

☐Address: _____ City: _____State:_____ Zip:_____
☑ IF SAME AS ABOVE PARENT
☐Home Telephone #:(_____)_____ Work #:(_____)_____ Cell#:(_____)_____

Birth Date: _____/_____/_____ SS#:_____Email Address: _____

Occupation: _____ Employer: _____Dept:_____

Employer's Address _____ City: _____State:_____ Zip:_____

DENTAL INSURANCE: Is child covered by this parent's insurance? Y N

Insurance Plan Name: _____ID#:_____ Group #:_____

EMERGENCY CONTACT If we are unable to contact the above parents/legal guardian, who should we contact?

Name(s): _____ Relationship to patient: _____

Home Telephone #:(_____)_____ Work #:(_____)_____ Cell#:(_____)_____

DO YOU HAVE CONCERNS ABOUT YOUR CHILD's DENTAL HEALTH, HABITS or TREATMENT?

- ☐ Emergency/accident
- ☐ Broken tooth
- ☐ Toothache/swelling
- ☐ Bleeding or swelling gums
- ☐ Cavities
- ☐ Staining/discoloration
- ☐ Crowding of teeth
- ☐ Need for orthodontia/braces
- ☐ Thumb or pacifier habit
- ☐ Bad breath
- ☐ Tongue thrusting
- ☐ Mouth breathing
- ☐ Teeth grinding
- ☐ Cleft lip/palate
- ☐ Fear or anxiety about dental visits
- ☐ Other concerns _____ _____

DENTAL HISTORY

Has your child ever been to the dentist? Y N (if no, skip to next section)

Name of previous dentist: _____ Phone#: _____City: _____ State:_____

Date of last visit: _____ Were teeth cleaned? Y N

Were X-rays taken? Y N Date of last x-rays: _____

Has your child experienced any unfavorable reaction from previous dental care? Y N

If yes, describe:_____

Has your child had local anesthetic? Y N Were there any problems?_____

Has your child received any dental or surgical treatment to the mouth? Y N

If yes, describe (i.e., sedated for dental treatment): _____

Have your child's teeth ever been injured? Y N Which teeth? _____ Cause? _____

Please describe dental treatment for trauma: _____

DIET

Does your child snack frequently? Y N If yes, what do those snacks usually consist of? _____

How much soda and juice does your child usually drink per day? _____

Please complete next page

Name of Patient _____

DENTAL HYGIENE

How many times a day does your child brush his/her teeth?

☐ 0-1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

How often does your child floss?

☐ never ☐ rarely ☐ at least 2x/wk ☐ every day ☐ more than 1x/day

Does your child take fluoride in any other form other than in toothpaste?

☐ No ☐ Water (tap or bottled) ☐ Vitamin or Supplement ☐ Other

Does a parent help your child to brush?

☐ No ☐ Yes

Do your child use an electric or motorized toothbrush?

☐ No ☐ Yes (brand _____)

Are you interested in learning more about Sonicare's For Kids toothbrush?

☐ No ☐ Yes

PARENT RESPONSIBILITIES

We are committed to providing you with the best possible care and helping your family achieve your optimum oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with our practice.

FINANCIAL RESPONSIBILITY

Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: cash, check, and any major credit card. Third-party financing is also available through CareCredit (www.carecredit.com).

_____ INITIAL I understand and acknowledge that I am financially responsible for the services provided for my child regardless of insurance coverage, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received within 60 days, I understand that a 1.5 % finance charge (18% APR) will be added to my account, including at $5 late fee, in addition to any collection charges.

DENTAL BENEFIT PLANS

Your dental benefit is a contract between you and your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help our patients with dental benefit plans to understand and maximize their coverage. We ask that you notify us with any changes to your employment or dental benefits.

_____ INITIAL **Financial Responsibility & Assignment of Benefits:** I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist/practice has a contractual agreement with my plan prohibiting all or a portion of such charges. I authorize direct payment of the dental benefits otherwise payable to me, to Dr. Andrew W. Yap, DDS.

_____ INITIAL **Release of Information:** To the extent permitted by law, I consent to the use and disclosure of my protected health information, including my signature and social security number, to carry out payment activities on all insurance submissions.

PATIENT INFORMATION AND PATIENT RIGHTS

_____ INITIAL **Facts about Fillings:** I have been given the opportunity to read and ask questions about "The Facts About Fillings," a dental material fact sheet providing information concerning the risks and benefits of all the dental materials used in the restoration (filling) of teeth.

_____ INITIAL **Privacy Notification:** I acknowledge that I have been given the opportunity to read and ask questions about this practice's "Notice of Privacy Practices," which describes how my information may be used or disclosed.

_____ INITIAL **Patient Records:** I understand that I have a right to request a copy of my family's dental records . I authorize the release of a portion or all of these records which are deemed useful for the diagnosis, treatment or consultation regarding my dental health, to other dental providers, dental specialists, and medical providers. I authorize the transmission of these records via e-mail and understand that there may be charges related to the duplication of xrays, should I request hardcopies.

SCHEDULING and CONFIRMATION OF APPOINTMENTS BY PHONE, TEXT MESSAGES AND/OR EMAIL

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of $40 or deposit to reserve the appointment time again, may be required.

_____ INITIAL I understand the scheduling policy and that I will be asked to confirm each and every appointment and can do so via phone, text or email.

CONSENT FOR TREATMENT

I authorize the dentist and his staff to take x-rays, study models, photographs, and/or any other diagnostic aids deemed appropriate by doctor to make thorough diagnosis of my dental needs. I understand that some of these images may be used by dental insurance carriers to determine benefits and by dental laboratories for the fabrication of crowns, veneers, bridges, dentures or other appliances and that these images will become a part of my permanent dental record. I also grant permission to reproduce, print and/or publish these images for use in articles, lectures, office website, or advertisements for the purposes of advancing medical-dental education and/or promoting cosmetic dentistry. I do not expect compensation, financial or otherwise, for the use of these images.

I also authorize dentist to perform all recommended treatment mutually agreed by me and to use the appropriate procedures, medication, anesthetics and therapy indicated for such treatment. I understand that using anesthetic agents embodies certain risk.

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in my health and/or medication. Further, I will not hold the dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Parent Signature _____ Date _____

When your child turns 18, we will ask your child to sign these consents as an adult and be responsible for their dental care with your help.

*Reviewed by Dentist:*_____ Date: _____