1507 West Yosemite Avenue • Manteca, CA 95337

(209) 823-9341•valleyoakdentalgroup.com

Welcome

Pediatric Patient Registration Form

Date: _____
Child's Name: _____
Sex: O M O F Age: _____ Birthday: _____
Who may we call to confirm your child's dental appointment by your home phone?
Name: _____ Best time to call: _____
Home address: _____ City: _____ State _____ Zip _____
Can we call you at work if can't confirm your child's dental appointment by your home phone? O Yes O No O Father O Mother
Work phone _____ Home phone _____ Cell phone _____
School attending: _____ Grade _____
What does your child like to talk about – sports, school, movies, music, etc. Please be specific: _____
_____
Do mother and father live together? O Yes O No
Names and ages of brothers and sisters:
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____
Name: _____ Age: _____

B Employment Information:

Father's name _____
Occupation _____
Employer _____
Work Address _____
_____
Work phone _____
Years _____ Month _____ D.O.B. _____
Social Security #: _____

Mother's Name _____
Occupation _____
Employer _____
Work Address _____
_____
Work phone _____
Years _____ Month _____ D.O.B. _____
Social Security #: _____

C Person Financially Responsible for Account

YOUR name: _____
Address: _____ City: _____ State: _____ Zip:_____
Phone: Day _____ Evening _____

DIVORCED PARENTS

1. NOTE: IF YOU ARE DIVORCED, THE PARENT THAT BRINGS THE CHILD INTO OUR OFFICE FOR DENTAL TREATMENT IS THE PERSON RESPONSIBLE FOR ALL CHARGES REGARDLESS OF YOUR DIVORCE DECREE.

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2. NOTE: IF YOU ARE NOT THE SAME PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT, PLEASE PRINT YOUR NAME HERE:

_____ SIGN HERE _____

D IF YOU DON'T HAVE DENTAL INSURANCE GO TO SECTION E

Primary Insurance Coverage

**Please specify the relationship of the insured to the child*

O Father O Mother O Step-father O Step-mother O Other _____
Dental Insurance Company Name: _____
Insurance Address: _____
Group _____ Policy # _____ Local # _____
Who is child's legal guardian if other than above? _____

IF SECOND INSURANCE PLEASE COMPLETE THE FOLLOWING:

O Father O Mother O Step-father O Step-mother O Other _____
Dental Insurance Company Name: _____
Insurance Address: _____
Group _____ Policy # _____ Local # _____

E Who may we contact "OUTSIDE" of your home in case of an emergency? Must be a friend or relative other than parent living at your address:

Name _____O Relative O Friend

Address: _____

Phone: Day _____ Evening _____

PERMISSION FOR DENTAL TREATMENT

I hereby give permission to VALLEY OAK DENTAL GROUP to render all necessary dental services and to use such methods and agents that are necessary for the child named on this form. I understand that no treatment will be started until the recommended treatment, time involved and the financial investment and arrangements have been discussed with me by the dentist or a staff member, at which time I may void this permission if I so choose. Furthermore, I will be responsible for any charges incurred by this child for dental treatment.

Date: _____ Signature _____

DENTAL INFORMATION

1. Is this an emergency visit? O Yes O No
2. Is this the first visit to the dentist? O Yes O No
3. Is your child apprehensive about this dental visit? O Yes O No
4. Would you describe your child as: O Shy O Frightened O Apprehensive O Eager O Aggressive
5. Has your child had any unfavorable dental or medical visits? O Yes O No
6. How would you expect your child to behave in our office? Describe: _____
7. Is there anything that you are particularly concerned about in regards to your child's dental health? O Yes O No
   If yes, explain: _____
8. Does your child have any of the following habits:
   O Thumb/Finger Sucking O Mouth Breathing O Nail/Lip Biting O Grind Teeth at Night O Tongue Thrust
9. Has your child been seen by an orthodontist? O Yes O No
10. Does your child brush daily? O Yes O No
11. Is dental floss used? O Yes O No
12. Is fluoride taken? O Yes O No If YES, under line how: (Drops, Tablets, Vitamins)
13. Have mother and father had a lot of tooth decay? O Yes O No
14. Do you feel your child's primary teeth are important to keep decay-free to prevent premature loss? O Yes O No
15. Have you heard of sealants that are applied to the tops of primary and permanent molars to prevent tooth decay? O Yes O No
16. Has either parent had difficulty getting numb? O Yes O No
17. Have there been any injuries to your child's teeth (falls, blows, chips, etc.)? O Yes O No If yes, explain:
    _____

PLEASE ANSWER THESE DENTAL QUESTIONS FOR A YOUNGER CHILD IF APPROPRIATE:

1. Do you assist your child in brushing his or her teeth? O Yes O No
2. At what age did your child stop using a nursing bottle? _____
3. When did your child's first tooth erupt? _____ months old
4. Would you be interested in having a consultation with a registered dietician in regards to nutrition and dental health for your child or family if recommended by your dentist? O Yes O No

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PLEASE ANSWER THESE DENTAL QUESTIONS FOR AN OLDER CHILD IF APPROPRIATE:

1. Does your child chew gum regularly? O Yes O No
2. Does your child eat more junk food than they should? O Yes O No
3. Are there any other habits you want us to be aware of? O Yes O No Please explain: _____
4. Would you be interested in having a consultation with a registered dietician in regards to nutrition and dental health if recommended by your dentist? O Yes O No

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Who may we thank for referring you to VALLEY OAK DENTAL GROUP? We want to thank them because we are always accepting new patients and we welcome all referrals. Name _____

AUTHORIZATION TO PAY BENEFITS

I hereby authorize payment directly to the undersigned, VALLEY OAK DENTAL GROUP, for dental benefits, otherwise made payable to me for dental services provided. I understand that I am financially responsible for all charges not covered by this authorization.

_____ _____

DATE SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT

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Pediatric Patient Medical History Information

Dear Parent:

This medical history form, although lengthy, is designed to help eliminate potential dangers your child could encounter in a dental office. These dangers can result from the doctor not being aware of your child's medical condition. Although some questions may appear unrelated to your child's dental treatment, we assure you they are in fact essential to your child's safety. Please take the time to answer each question to the best of your ability.

GENERAL INFORMATION

Name of your child or young adult: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: O M O F

Physician's or Pediatrician's Name: _____ Phone number: _____

Address: _____ City: _____ State: _____

Who may we contact in case of emergency other than parent: _____

Home phone: _____ Work phone: _____

Relationship to your child: _____

HISTORY OF MEDICAL CONDITION AND ILLNESSES

KEY **N-**Never had this condition **P-** Previously had this condition **C-**Currently have this condition

Please circle the appropriate response for each of the following:

BONE AND JOINT DISORDERS		HEART DISORDERS		MUSCLE DISORDERS	
Rheumatoid Arthritis	N P C	Heart Murmur	N P C	Muscle tension	N P C
Osteoarthritis	N P C	Heart valve disorder	N P C	Muscular Dystrophy	N P C
Joint Prosthesis	N P C	Other		Frequent muscle spasms	N P C
Other				Other	
BLOOD DISORDERS		**HIV DISORDERS**		**NERVE DISORDERS**	
Prolonged Bleeding	N P C	AIDS	N P C	Cerebral Palsy	N P C
Anemia	N P C	ARC	N P C	Epilepsy	N P C
Leukemia	N P C	HIV Positive	N P C	Neuralgia	N P C
Sickle Cell	N P C			Multiple Sclerosis	N P C
Cancer	N P C	**KIDNEY, URINARY DISORDERS**		Brain Injury	N P C
Other		Kidney Disease	N P C	Other	
ENDOCRINE (GLAND) DISORDERS		Bladder Infections	N P C		
Diabetes	N P C	Other		**STOMACH, INTESTINAL DISORDERS**	
Other				Hiatal Hernia	N P C
EYE DISORDERS		**LIVER DISEASE**		Other	
Glaucoma	N P C	Hepatitis A (Infectious)	N P C		
Ocular Herpes	N P C	Hepatitis B Serum	N P C	**OTHER CONDITIONS**	
Does your child wear contacts?	N P C	Other		Psychiatric disorders	N P C
Other		**LUNG DISORDERS**		Tumors or malignancies	N P C
HEADACHE		Asthma	N P C	Venereal Disease	N P C
Tension Headache	N P C	Emphysema	N P C	Radiation treatment	N P C
Migraine Headache	N P C	Tuberculosis	N P C	Whiplash injury	N P C
Unexplained Headache	N P C	Difficulty breathing	N P C	Pain in jaw joints	N P C
Other		Other		TMJ problems	N P C
				Other	

PLEASE CIRCLE YES OR NO TO THE FOLLOWING IMPORTANT QUESTIONS:

1. Is your child allergic to (itching, rash, hives, swelling of hands, feet or eyes) or had an adverse reaction to (made sick from):

Penicillin ……..	YES NO	Food ……..……..	YES NO
Aspirin ……..	YES NO	Animals ……..……..	YES NO
Codeine ……..	YES NO	Pollen ……..……..	YES NO
Local anesthetic ……..….	YES NO	Dust ……..……..	YES NO
Medications or drugs ……..….	YES NO	Insects or bee stings ……..……..	YES NO

2. Has your child ever had a Rheumatic Fever? ……..…….. YES NO
3. Has your child developed Rheumatic Heart Disease as a result? …….. YES NO
4. Has your child ever bled excessively after being cut or injured? ……..…….. YES NO
5. Has your child been a patient in the hospital in the last three (3) years? …….. YES NO
6. Has your child been under care of a physician during the past (2) years? …….. YES NO
   Is your child receiving physician's care now? _____ If so, what is the nature of the care?
   _____
   _____
   _____
   _____
7. Does your child have any diseases, condition or problem not listed or that should be brought to the dentist's attention? …….. YES NO
8. Has your child ever fainted? …….. YES NO
9. Has your child ever had any radiation or chemotherapy? ……..…….. YES NO
10. Would you like to speak privately to the Doctor about any problem? ……..…….. YES NO

MEDICATIONS

List all medications your child is taking now, the dosage, how often and the reasons.

Medication	Dosage	How often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has any changes in his/her health, or if their medications change, I will inform the doctor of dentistry at the next appointment without fail.

_____	_____	_____
Date	Parent's Signature	Doctor's Signature

Supplemental Health History Form

Patients Name:_____ File #:_____

Has your child ever been diagnosed with, or shown any signs of the following behavioral conditions:

O Autism – Level _____

O ADHD

O Tourette Syndrome

O Anxiety Disorder

O Depression

O Cerebral Palsy

If yes, date of diagnosis: _____

Parent/Guardian signature:_____ Date: _____

VALLEY OAK DENTAL GROUP

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENT CAREFULLY.

Purpose of Consent: By signing this form, you will consent to out use and disclosure of your protected health information to carry out treatment, payment and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Out Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:

Contact Person:	Maya Reft		
Telephone:	(209) 823-9341	Fax:	(209) 823-7836
E-mail:	valleyoakdentalgroup@gmail.com		
Address:	1507 W. Yosemite Ave, Manteca CA 95337		

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____ Date _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

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Allowable Fees

In an ongoing effort to serve you, we would like to help you understand your insurance benefits and patient statements.

We strive to give the most accurate financial estimates based on the information that your insurance carrier gives to us. No one likes surprises, and we try very hard to ensure that you understand the cost of your dental treatment prior to receiving care.

It is important that you understand that until we actually receive payment from your insurance company, we can only provide an estimate of your share of costs.

We are increasingly aware of insurance companies who base their payments on what they call an "allowable fee" rather than our usual and customary fee. Generally, the allowable fee is an internal, unpredictable amount that is less than our fee. This effectively lowers your insurance benefit. 100% coverage can sometimes be less than payment in full when the "allowable fee" is less than our usual and customary fee.

Explanation of Benefits

Please be sure to review your "Explanation of Benefits" that should be sent to you by your insurance company within 3-4 weeks after your appointment. This will show you the amount we have billed, your insurance company's "allowable fees", the amount they paid and your expected patient responsibility. As always, if there is something you do not understand, we encourage you to call right away and we will be happy to assist you in understanding your billing statements or your insurance correspondence.

Assignment of Benefits

I assign all dental payments to which I am entitled from any Insurance Company to Valley Oak Dental Group. I wish this to stay in effect until revoked by me in writing. I understand that I am financially responsible for all charges if they are not paid by my Insurance Company within 30 days from claim and billing date (professional services are rendered and charged to the patient or guardian and not to the Insurance Company).

Collection Fees

In the event that legal action is necessary to collect a debt, ALL fees associated with collection, including but not limited to, attorney fees will be assessed and are the responsibility of the patient and/or account holder.

I authorize Valley Oak Dental Group to release any dental information to my Insurance Company. I wish this to stay in effect until revoked by me in writing.

I have read this agreement and understand it. I have also received a copy of this agreement.

Patient or Patient's Guardian Date