Specialists In Dentistry For Children

Marilou Navarro DDS & Associates

Tell Us About Your Child

Today's Date: _____Child's Home Phone#:(_____)_____Social Security #_____

Child's Name: _____Child's Birthdate:_____/_____/_____ Child's Age:____

School:_____ Grade: _____ ☐ Male ☐ Female

Who may we thank for referring you?_____

What is the primary reason for today's visit? _____

Has any member of your family been or is current patient in this office: ☐ Yes ☐ No

If Yes, name:_____

Dental History

Is your child currently in pain? ☐ Yes ☐ No

Is this your child's first time seeing a dentist? ☐ Yes ☐ No

Has your child experienced problems with previous dental work? ☐ Yes ☐ No

Previous Dentist:_____ Date of Last visit:_____ Date of Last X-ray:_____

Have there been any injuries to your child's teeth, jaws, falls, blows, chips, etc. ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child brush his/her teeth daily? ☐ Yes ☐ No Does he/she require parental help? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ☐ Yes ☐ No Does he/she require parental help? ☐ Yes ☐ No

Does/Did your child have any of the following habits (please circle)

☐ Lip sucking and Nail Biting	☐ Clenching/Grinding Teeth	☐ Tongue/ Cheek Biting	☐ Mouth Breather
☐ Chewing on Objects	☐ Thumb/Finger Sucking	☐ Used Pacifier	☐ Speech Problems
☐ TMJ/TMD Pain	☐ Nursing Bottle Habits	☐ Tongue Thrust	☐ Breast Fed

Medical History

Child's Physician_____ Phone(__)_____ Date of last visit:_____

Address:_____

Is your child under the care of a physician? ☐ Yes ☐ No. If yes, please explain:_____

Does your child have social/personality/temperament concerns that we should be aware of?_____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all medications and dosage that your child is currently taking:_____

Please list all food and drugs and/or things that cause your child allergic reactions:_____

Anything you would like to discuss with the Doctor in Private? ☐ Yes ☐ No

Has your child had/Experienced any of the following?

Abnormal bleeding	☐Y ☐N	Chicken Pox	☐Y ☐N	Heart Murmur	☐Y ☐N	Mononucleosis	☐Y ☐N
AIDS/HIV	☐Y ☐N	Congenital Birth Defect	☐Y ☐N	Hemophilia	☐Y ☐N	Frequent Headaches	☐Y ☐N
Allergies	☐Y ☐N	Congenital Heart Defect	☐Y ☐N	Hepatitis	☐Y ☐N	Rheumatic	☐Y ☐N
Anemia	☐Y ☐N	Diabetes	☐Y ☐N	High Blood Pressure	☐Y ☐N	Seizures	☐Y ☐N
Any Hospital Stays	☐Y ☐N	Endocrine System Disorder	☐Y ☐N	Hives	☐Y ☐N	Scarlet fever	☐Y ☐N
Any Operation	☐Y ☐N	Epilepsy	☐Y ☐N	Kidney Problems	☐Y ☐N	Sickle Cell Anemia	☐Y ☐N
Asthma	☐Y ☐N	Frequent Infections	☐Y ☐N	Liver/GI System Problems	☐Y ☐N	Sight Disorders	☐Y ☐N
Blood Dyspraxia	☐Y ☐N	Handicaps	☐Y ☐N	Low Blood Pressure	☐Y ☐N	Significant Injuries	☐Y ☐N
Blood Transfusion	☐Y ☐N	Behavior/Learning Disorder	☐Y ☐N	Lupus	☐Y ☐N	Skin Rash	☐Y ☐N
Breathing/Lung Problem	☐Y ☐N	Mentally/Physically Disabled	☐Y ☐N	Measles	☐Y ☐N	Tonsillitis	☐Y ☐N
Cancer/Tumor	☐Y ☐N	Hearing Impaired	☐Y ☐N	Mitral Valve Prolapsed	☐Y ☐N	Tuberculosis	☐Y ☐N

Please discuss any serious medical problems your child experiences(ed): _____

Signature:_____ Date:_____

Specialists In Dentistry For Children

Marilou Navarro DDS & Associates Inc.

Tell Us About Your Child

Today's Date: _____Child's Home Phone#:(_____)_____Social Security #_____

Child's Name: _____Child's Birthdate:_____/_____/_____ Child's Age:____

Home Address: _____

Person responsible for this account:_____

Child Lives with: ☐ Both Parents (Same Household) ☐ Both Parents (Separate Household) ☐ Father ☐ Mother

Parents Information

Father's Name _____Soc. Sec. # _____

Drivers License # _____ Birthdate _____

Address (if different from above): _____

Employer: _____ Since: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

FATHER's DENTAL INSURNACE CO: _____

Ins. Address: _____ Group No: _____

_____ Ins. Phone: _____

Mother's Name _____ Soc. Sec. # _____

Drivers License # _____ Birthdate _____

Address (if different from above): _____

Employer: _____ Since: _____ Occupation: _____

Employer's Address: _____ Work Phone: _____

MOTHER's DENTAL INSURNACE CO: _____

Ins. Address: _____ Group No: _____

_____ Ins. Phone: _____

Emergency Contact

In the event of an emergency if we are unable to reach you, please give us the name and the number of a friend, neighbor (not listed above) that we may contact:

Name: _____ Phone: _____

Disclosures

Dental Insurance: As a courtesy, we will assist you in obtaining reimbursement from your insurance carrier. However, responsibility for payment of services and collections of disputed insurance claims lies with you.

I authorize this office to release dental radiographs (x-rays) if requested by another office.

Office Policy: We require payment for dental services at the time they are rendered unless other plans have been made in advance. If you need other financial arrangements our front office coordinator can discuss MasterCard, Visa and budget plans with you. All accounts over 30 days delinquent may be charged 2% service charge per month.

Broken Appointments: There will be a $50.00 charge unless 24 hour notice is given.

- I authorize this office to obtain a credit report for the purpose of extending credit to my family.
- I acknowledge full responsibility for the payments of Dr. Marilou Navarro and Associates services and agree that I
- will take responsibility for any and all costs incurred by my failure to remit for services rendered.
- I have given any and all information truthfully and accept full responsibility for any inaccuracy.

Signature:_____ Date:_____

HIPAA Privacy Rule Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description *of* the uses and disclosures of my health information. I understand that:

- I have the right to review this facility 's Notice of Privacy Practices prior to signing this acknowledgement;
- this facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

X Signature of Individual or Legal Representative Witness .....

Printed Name of Individual or Legal Representative .....

Witness.....

Date: .....

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barrier prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Others (please specify)

_____

_____

_____

_____ _____

HIPAA Officer Date

(OVER)

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this faciliy's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- this facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Legal Representative Witness .....

X Printed Name of Patient or Legal Representative Witness .....

Date: .....

Specialists In Dentistry For Children
Marilou Navarro DDS & Associates Inc.
Dr. Marilou Navarro, DDS
Dr. Jeff Alcaide, DDS
Dr. Derek Banks, DDS
Dr. Benson Wong, DDS, Orthodontist
750 Capitol Ave, Suite C-2, San Jose, Ca. 95133

Financial Policy

Patients name:_____

_____PAYENT METHOD: Payments are due at the appointment time. Cash paying patients, are required to pay in full and we will honor a 10% discount. We will estimate the portion of insurance to be paid, as quoted by the insurance company. If a copayment is due it will be collected at the time of service. After insurance pays, you may still owe an additional out of packet payment. We will bill you for any additional payments due. We accept all major credit cards, checks, cash and we also work with a third party financial company. A $25 fee will be charged for returned checks. If funds are denied on your credit card there will also be an additional charge of $25. A finance charge will apply on a balance over 60 days at the rate of 1.5%. We do our best to make your visit and finances as comfortable as possible

_____INSURANCE: We do accept insurance, however, **we are not contracted with any PPO plans.** We would be considered an out of network provider. This may mean that the insurance companies allowable fees may not be the same as our fees. We do not accept any HMO Plans, on those plans you do need to choose a doctor off of a list. No payment of insurance can be guaranteed. The insurance companies give a disclaimer of this on each phone call. We must emphasize that, as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

_____APPOINTMENT POLICY: We require a 48hour notice to cancel or reschedule an appointment. We will charge a minimum of $50. We will keep any deposits that are required to preschedule an appointment if you cancel less than 24hr notice or if your child eats or drinks for oral conscious sedation or IV sedation. You will need to repay to reschedule your child.

_____

Print Parent or Guardians name

_____ _____

Parent or Guardians signature Date

Specialists In Dentistry For Children
Marilou Navarro DDS & Associates Inc.
Dr. Marilou Navarro, DDS
Dr. Jeff Alcaide, DDS
Dr. Derek Banks, DDS
Dr. Benson Wong, DDS, Orthodontist
750 Capitol Ave, Suite C-2, San Jose, Ca. 95133

Parent/Legal Guardian Acknowledgement of Receipt of Dental Materials Fact Sheet

Pursuant to California State Law, I have been given a copy of Dental Material Facts Sheet to read. I have had the opportunity to discuss this information and ask questions. I will receive a copy of the fact sheet upon my request.

_____ _____

Patient/Legal Guardians Signature Date