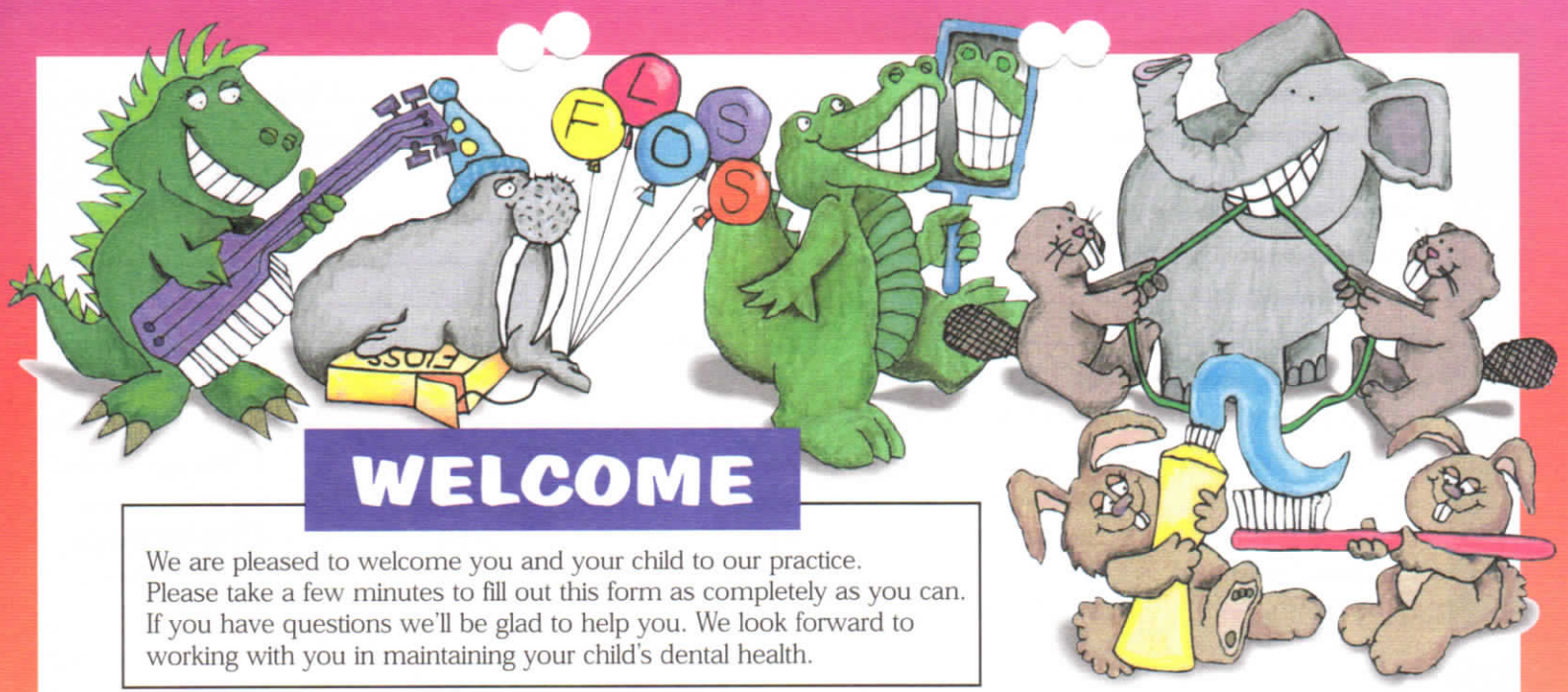


WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Date _____

PATIENT INFORMATION

Name of Minor/Child _____ (Last Name) (First Name) (Initial)

Sex ☐ M ☐ F Age _____ Birthdate _____ Nickname _____ Hobbies _____

Home Address _____ (Street) (City) (State) (Zip)

Mailing Address _____ (Street) (City) (State) (Zip)

Person financially responsible _____ Home Phone _____ Work Phone _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone _____ (if different from above) Work Phone _____ (if different from above)

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone _____ (if different from above) Work Phone _____ (if different from above)

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____

Phone No. _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐

Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications _____

_____

_____

Allergies _____

_____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✔)

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

AUTHORIZATION

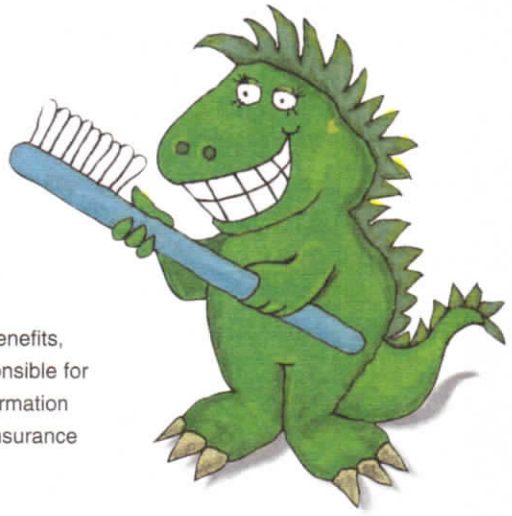
The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

_____

Signature of Parent/Guardian

_____

Date



I certify that my minor/child is covered by insurance with:

_____

Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of Parent/Guardian

_____

Date

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe _____

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Sandi E. Silva, DDS, Inc.
13422 Newport Avenue, Suite A
Tustin, CA 92780
714-544-5883
SilvaSmileDesigns@gmail.com

Dental Insurance Policy

As a courtesy we are happy to file the necessary forms to see that you receive the full benefits of your coverage from your insurance company. We are happy to do this for you no matter whether we are "in-network" or "out-of-network" with your insurance company. At the time of service we will need to collect the estimated co-payment. Please understand that this is an estimate based on information provided to us by your insurance company. After the claim is filed the insurance company may adjust the co-payment amount. We will do all we can to make sure you get the maximum benefit from your coverage including addressing any requests for additional information. In most cases, we can successfully resolve any disputes. If a situation arises where we are unsuccessful we will gladly provide you all necessary documentation if you choose to address the dispute with your insurance company. Please understand that your dental insurance contract is between you, your employer, and the insurance company.

Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health insurance. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multipole healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time to obtain a current copy of this notice. I understand that I may request in writing that you restrict how my private information is used or disclosed.

Cancellation Policy

We love to take good care of our patients in a timely and non-rushed manner. In order to do this we are very careful with how we schedule to minimize the chance of wait times and make sure the specified time is reserved just for you. We have implemented email and text reminders to help in this process. We kindly ask that you give us at least 48 hours notice if you need to change your appointment time. This way we have enough time to offer your reserved time to another patient who may need that time. Any cancellations made in less than 48-hours may be subject to a $50.00 fee.

Patient Name:_____ Date:_____