PEDIATRIC dental center

MICHELLE M. KELMAN, DDS

PEDIATRIC DENTIST

Child's Name: _____

(First) (Middle) (Last)

Sex: ___M ___F Age: _____ Birth date: ____ / ____ / ____ Place of Birth: _____

School: _____ City: _____

Pediatrician Name: _____

Whom may we thank for referring you to our office? _____

Name(s) of Sibling(s): _____

WHAT IS YOUR CHILD'S HEALTH AND MEDICAL HISTORY

Has your child had any bad dental or medical experiences in the past? ___Yes ___No

Please explain: _____

Does your child take a bottle to bed at bedtime or nap time? _____

Do you brush your child's teeth? _____ What time of day? _____

Do you use toothpaste? _____ What brand? _____ How much? _____

Does your child use a pacifier? ___Yes ___No

Does your child suck his/her thumb or fingers? _____ Does your child grind at night/day? _____

Other oral habits: _____

Was your child bottle or breast fed? _____ At what age was he/she weaned to solid foods? _____

Are your child's immunizations up to date? ___Yes ___No

Does your child have any allergies or reactions to any medicine? ___Yes ___No If yes, to what: _____

Does your child have allergies to any of the following? Eggs___ milk___ latex___ dust___ pollen___ other: _____

Please explain: _____

Has your child ever been diagnosed as having any of the follow conditions?

Anemia	___Yes / ___ No	Excessive Gagging	___ Yes / ___ No
Asthma	___Yes / ___ No	Eye Problems	___ Yes / ___ No
Autism	___Yes / ___ No	Fainting or Dizziness	___ Yes / ___ No
Bladder Conditions	___Yes / ___ No	Heart Problems	___ Yes / ___ No
Blood Transfusion	___Yes / ___ No	Hearing/Speech Problems	___ Yes / ___ No
Brain Injury	___Yes / ___ No	Hemophilia	___ Yes / ___ No
Bruising easily	___Yes / ___ No	Hyperactivity	___ Yes / ___ No
Cancer or Malignancies	___Yes / ___ No	Kidney Disease	___ Yes / ___ No
Cerebral Palsy	___Yes / ___ No	Kidney/ Liver Disease	___ Yes / ___ No
Chronic Headaches	___Yes / ___ No	Liver Disease	___ Yes / ___ No
Convulsions/Seizures	___Yes / ___ No	Nutritional Deficiency	___ Yes / ___ No
Developmental Delay	___Yes / ___ No	Oral Ulcer	___ Yes / ___ No
Diabetes	___Yes / ___ No	Orthopedic Problems	___ Yes / ___ No
Ear Infection	___Yes / ___ No	Rheumatic Fever	___ Yes / ___ No
Emotional Disturbance	___Yes / ___ No	Scoliosis	___ Yes / ___ No
Epilepsy	___Yes / ___ No	Tonsil Problems	___ Yes / ___ No

Please explain: _____

Please list medications child is currently taking and what they are being taken for:

_____

I hereby authorize dental examination and whatever services deemed necessary by Michelle M. Kelman, D.D.S.

_____ _____

Parent/Guardian Signature Date

CEDARS-SINAI MEDICAL TOWERS

8635 W.3rd Street, Suite 255 West, Los Angeles, CA 90048 Tel.310.659.8863 Fax 310.659.9185

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PARENT/GUARDIAN INFORMATION: (Please check preferred contact method)

☐ **(#1) Name:** _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Pager: _____

*** E-mail:** _____

Date of Birth: ____ / ____ / ____ SSN: _____

Driver License #: _____ State: _____

Occupation: _____ Employer Name: _____ Work Phone: _____

☐ **(#2) Name:** _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell/Pager: _____

*** E-mail:** _____

Date of Birth: ____ / ____ / ____ SSN: _____

Driver License #: _____ State: _____

Occupation: _____ Employer Name: _____ Work Phone: _____

Who does the child live with? ___*Both Parents ___*Mother ___*Father ___*Other

Name of person responsible for this account: _____

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CONSENT FOR GENERAL DENTAL TREATMENT and PRIVATE PRACTICES

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, digital radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite.

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. Please read this form carefully and ask about anything you do not understand. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child.

Any other treatment needed such as fillings, sealants, crowns, extractions, etc. will be performed at a separate appointment after obtaining your permission. State Law requires that we obtain your written informed consent for any treatment given to your child as a legal minor.

I hereby authorize and direct Dr. Michelle Kelman assisted by other dentists and/ or dental auxiliaries of the doctor's choice, to perform upon my child recommended dental treatment including:

a.	Any necessary or advisable intra-oral pictures	Initial: _____
b.	Radiographs (x-rays), if necessary	Initial: _____
c.	Diagnostic aids: Aids used in oral hygiene instructions	Initial: _____
d.	Cleaning of Teeth	Initial: _____
e.	Application of Fluoride	Initial: _____
£.	Use of behavior management techniques, if needed	Initial: _____
g.	Limited/Comprehensive Oral Exam by the Doctor	Initial: _____

I understand that the purpose and benefit of the treatment indicated above is to preserve, maintain, and restore the Child's general dental health and/or to alleviate and prevent specific tooth and mouth pain.

Alternate procedures or methods of treatment, if any, have been fully explained to me, as have the advantages and disadvantages, the risks, consequences and probable effectiveness of each proposed treatment, as well as the prognosis if no treatment is provided. I have been fully advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantees, expressed or implied, as to the result of the treatment or as to a final cure.

I hereby state that I have read and understand this consent and the behavior management techniques discussed with me and that all questions about the procedures have been answered in a satisfactory manner; and I understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent shall remain in effect until such time as I choose to terminate such consent and communicate the fact of such termination to the Doctor or to her representative.

I have received a copy of the Pediatric Dental Center Notice of Privacy Practices and have had an opportunity to read the Notice of Privacy Practices. I understand that I may ask questions directly to the Pediatric Dental Center front office coordinator or Dr. Michelle Kelman if I do not understand information contained in the Notice of Privacy Practices. I understand I can request a printed copy of the Notice of Privacy Practices.

Print Name of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Relationship to Patient: _____ Time: _____ AM/PM

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I consent to the use or disclosure of my child's protected health information by **Pediatric Dental Center** for the purpose of analyzing, diagnosing or providing treatment to my child, obtaining payment for my child's health care bills or to conduct health care operations of **Pediatric Dental Center**. I understand that analysis; diagnosis or treatment of my child by **Pediatric Dental Center** may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my child's protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Pediatric Dental Center** is not required to agree to the restrictions that I may request. However, if **Pediatric Dental Center** agrees to a restriction that I request, the restriction is binding on **Pediatric Dental Center**. I have the right to revoke this consent, in writing, at any time, except to the extent that **Pediatric Dental Center** has taken action in reliance on this Consent.

My child's "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my child's past, present or future physical or mental health or condition and identifies my child, or there is a reasonable basis to believe the information may identify my child.

I have been provided with a copy of the Notice of Privacy Practices of **Pediatric Dental Center** and understand that I have a right to review the Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my child's protected health information that will occur in my child's treatment, payment of my child's bills or in the performance of health care operations of **Pediatric Dental Center**. The Notice of Privacy Practices for **Pediatric Dental Center** is also posted in the waiting room at **8635 W. 3rd Street, suite 255W, Los Angeles, CA 90048**. This Notice of Privacy Practices also describes my rights and duties of the **Pediatric Dental Center** with respect to my child's protected health information.

Pediatric Dental Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office of **Pediatric Dental Center** and requesting a revised copy be sent in the mail or asking for one at the time of my child's next appointment.

Parent/Guardian Signature

Date

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PATIENT WITH DENTAL INSURANCE

Pediatric Dental Center will submit insurance claim to your insurance company in your behalf. As your dental care provider, our relationship is with you, not necessarily with your insurance company. Unless we are contracted with your insurance plan, payment is due in full at the time of service. The filing of insurance claims is a courtesy we extend to our patients. We accept no responsibility in the collection of any insurance claims or in the negotiation of any settlements on disputed claims. In the event, we receive any overpayment on your account by your insurance company; we will either credit your account or issue a refund check, when requested.

The following information will be used to submit your claim to your insurance company:

PRIMARY CARRIER:

Subscriber Name: _____
Subscriber S.S. # _____
Subscriber DOB: _____
Employer Name: _____
Insurance Company: _____
Insurance tel. # _____
Plan ID: _____
Plan Group # _____

SECONDARY CARRIER:

Subscriber Name: _____
Subscriber S.S. # _____
Subscriber DOB: _____
Employer Name: _____
Insurance Company: _____
Insurance tel. # _____
Plan ID: _____
Plan Group # _____

X _____
Please Print Name of Parent/Guardian

X _____
Signature of Parent/Guardian

Relationship to Patient: _____ **Date:** ____ / ____ / ____ **Time:** _____**am / pm.**

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FINANCIAL POLICY

Thank you for choosing the Pediatric Dental Center as your child's dental health care provider. We are committed to your child's treatment being successful. The following is a statement of our financial policy which we require you to read and sign prior to any dental treatment. All parents must complete our Patient and Family Information and Health History Form prior to treatment.

OUR POLICY IS AS FOLLOWS:

- The parent or legal guardian of the minor patient is responsible for full payment at the time of service. The financially responsible party MUST be present at the time of treatment.
- We accept cash, personal checks, MasterCard, Visa and American Express. (Returned checks are subject to a $25 fee)
- Payment Arrangements are available at the discretion of our financial coordinator prior to treatment.

REGARDING DENTAL INSURANCE

- Your insurance is a contract between you, your employer and the insurance company. We are not responsible for how your insurance company processes claims or what benefits are payable. Insurance companies set their own fee schedules and percentages paid are based on their fees on file, not our office fees.
- Please note, not all services are covered benefits in all contracts, such as composites restorations (white fillings), Nitrous Oxide or sealants on primary teeth.
- In most cases, we accept assignment of insurance benefits, meaning the insurance company reimburses our office directly due to a contract with the insurance. Your deductible and/or estimated portion is due at the time services are rendered.
- You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates at the time of your child's appointment.
- Most importantly, please inform our office of ANY changes with your insurance coverage.

Please contact our financial manager if you have any questions about our fees, financial policy or your responsibility. Thank you for your trust and confidence.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY. I UNDERSTAND I AM RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE. I AUTHORIZE PAYMENT TO BE MADE DIRECTLY TO THE DENTIST BY MY INSURANCE COMPANY AND I ACCEPT FINANCIAL RESPONSIBILITY FOR ALL SERVICES NOT COVERED BY MY INSURANCE.

Parent Signature: _____ **Date:** _____

Printed Name: _____

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TRANSFER AND CORRESPONDENCE OF YOUR CHILD'S HEALTH CARE INFORMATION VIA EMAIL

PLEASE NOTE: We are happy to respond to your request, but in order for us to do so via email, you must provide your consent, recognizing that email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by unauthorized third parties. We will use the minimum necessary amount of protected health information to respond to your request.

REQUEST CONSENT FORM

I authorize Pediatric Dental Center and any doctors and employees to send information that I requested to my email address provided below. This consent form will be effective until I notify Pediatric Dental Center to discontinue.

Your Name: _____ Relation to Child: _____

Child's Name: _____

Email Address: _____

Signature: _____ Date: _____

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PRACTICE POLICIES

CANCELLATION POLICY

We strive to accommodate the appointment needs of our patients, and make every effort to keep on time for appointments scheduled. Your child's appointment time in this office is reserved exclusively for their treatment. If their appointment time becomes inconvenient for you, we are always happy to change it if you provide us with two-business days (48 hours) notice. This allows us to schedule in a patient who may be in urgent need of our care. Failure to provide us with 48 hours advance notice or failure to appear for a scheduled appointment will result in a cancellation or no show fee.

1st missed appointment: If an appointment is missed or canceled within the 48-hour window, a **$75** no show fee will be billed to your account. This no show fee must be paid before scheduling your next appointment.

2nd missed appointment: If a second appointment is missed or canceled within the 48-hour window, another **$75** no show fee will be billed to your account. In order to schedule a future appointment with our doctor, a deposit of 100% of the cost of that appointment treatment must be made. **If the patient does not show up to the appointment, the deposit is non-refundable.**

After a third "no show", it will be at our discretion if a patient will be released from the practice. If released from the practice, we will provide treatment 30 days on an emergency basis only to give you an opportunity to find another dental office.

It is understandable that sometimes cancellations cannot be helped due to illness or emergency and we will take all valid circumstances into account.

LATENESS POLICY

When we reserve time for your child, we require all of that time to provide them with the best quality work possible. When you are late it decreases our ability to accomplish this. If you are late, we may not be able to complete the entire treatment. If you arrive more than 10 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment and appropriate no show fee will be applied to your account.

By signing below I certify that I have read and understand the terms and conditions of Pediatric Dental Center's policies listed above:

Signature of Financially Responsible Party: _____ Date: _____

Print Name of Financially Responsible Party: _____

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