



CAPITAL PEDIATRIC DENTISTRY

David J Crippen, DDS, Inc

WELCOME!

Today's Date:

PATIENT INFORMATION

Patient's name:			Nickname:	Siblings:
Birth date:	Age:	Gender:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Weight:
Street address:				Home Phone: ()
City:		State:	Zip:	

Do you require language assistance provided by your insurance company? <input type="checkbox"/> YES <input type="checkbox"/> NO	What language?
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Whom may we thank for referring you to our practice?
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GUARDIAN INFORMATION

Guardian marital status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed <input type="checkbox"/> Remarried <input type="checkbox"/> Single <input type="checkbox"/> Partner		
Guardian name:	Relation to Patient:	Social Security #:
Birth Date:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email:
Employer:	Occupation:	Work Phone:
Street address:	Home Phone:	Cell Phone:
City:	State:	Zip:
Guardian name:	Relation to Patient:	Social Security #:
Birth Date:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email:
Employer:	Occupation:	Work Phone:
Street address:	Home Phone:	Cell Phone:
City:	State:	Zip:

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Name:	Relation to Patient:	Social Security #:
Birth Date:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Email:
Employer:	Occupation:	Work Phone:
Street address:	Home Phone:	Cell Phone:
City:	State:	Zip:

INSURANCE INFORMATION

Insurance Company Name:	Phone #:	Group Number:
Policy Owner's Name:	Policy Owner's Birth Date:	Relation to Patient:
Policy Owner's Employer:		Subscriber ID#:
Insurance Company Name:	Phone #:	Group Number:
Policy Owner's Name:	Policy Owner's Birth Date:	Relation to Patient:
Policy Owner's Employer:		Subscriber ID#:

Patient name: _____

DENTAL HISTORY

Is this the child's first dental visit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of previous dentist:
Date of last dental exam:		Date of last dental cleaning:
Is the child's water fluoridated?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the child taking fluoride supplements? <input type="checkbox"/> Yes <input type="checkbox"/> No
Is the child currently in pain?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Is the child apprehensive? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has the child had a negative dental experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please explain:

Does the child have any of the following habits?

<input type="checkbox"/> Y <input type="checkbox"/> N Prolonged Breast Feeding	<input type="checkbox"/> Y <input type="checkbox"/> N Clenching/Grinding Teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather
<input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habits	<input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking/Biting/Licking	<input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust
<input type="checkbox"/> Y <input type="checkbox"/> N Thumb/Finger Sucking	<input type="checkbox"/> Y <input type="checkbox"/> N Tongue/Cheek Biting	<input type="checkbox"/> Y <input type="checkbox"/> N Snoring
<input type="checkbox"/> Y <input type="checkbox"/> N Pacifier Use	<input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting	<input type="checkbox"/> Y <input type="checkbox"/> N Excessive Gagging

MEDICAL HISTORY

Medical Insurance Carrier:	Medical #:
Physician's name:	Physician's phone #:
Date of last physical exam:	Are immunizations current? <input type="checkbox"/> Yes <input type="checkbox"/> No
Does the child have any allergies ?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes:
Is the child taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes:
Has the child ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes:
Has the child had anesthesia and/or sedation?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes:

Does the child have any of the following:

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Seizures	<input type="checkbox"/> Y <input type="checkbox"/> N Lung/Breathing Problems
<input type="checkbox"/> Y <input type="checkbox"/> N ABO Incompatibility @ Birth	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Mental Disturbances/Delays
<input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV	<input type="checkbox"/> Y <input type="checkbox"/> N Emotional Disturbances	<input type="checkbox"/> Y <input type="checkbox"/> N Mononucleosis
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia/Other Blood Disorders	<input type="checkbox"/> Y <input type="checkbox"/> N Hormone/Thyroid	<input type="checkbox"/> Y <input type="checkbox"/> N Physical Development Delays
<input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays/Surgery	<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Pregnancy
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bone or Joint Implants	<input type="checkbox"/> Y <input type="checkbox"/> N Frequent Infections (Ear/Tonsil)	<input type="checkbox"/> Y <input type="checkbox"/> N Reaction to Latex
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disability	<input type="checkbox"/> Y <input type="checkbox"/> N Recreational Drug Use
<input type="checkbox"/> Y <input type="checkbox"/> N Attention Deficit Disorder/ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N Hearing/Sight Impairments	<input type="checkbox"/> Y <input type="checkbox"/> N Recurring/Frequent Headaches
<input type="checkbox"/> Y <input type="checkbox"/> N Behavioral/Learning Difficulties	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murrur/Mitral Valve Prolapse	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion (Date:)	<input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia	<input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Anemia
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer/Tumors	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N Cleft Lip and/or Palate	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Speech Disturbance
<input type="checkbox"/> Y <input type="checkbox"/> N Complete Blood Exchange @ Birth	<input type="checkbox"/> Y <input type="checkbox"/> N Injury to Head, Neck, Jaw or Teeth	<input type="checkbox"/> Y <input type="checkbox"/> N Syndrome
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Birth Defects	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney/Liver/GI Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Reaction to Anesthetics
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)
<input type="checkbox"/> Y <input type="checkbox"/> N Does the child have any disease, condition or problem not listed that you think we should know about?		

Please explain any "yes" answers:

Authorization

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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 my child may need.

I hereby assign directly to Capital Pediatric Dentistry any and all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. 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 of my insurance submissions, whether manual or electronic.

Parent/Guardian Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____



CAPITAL PEDIATRIC DENTISTRY

David J Crippen, DDS, Inc

OFFICE AND FINANCIAL POLICIES

Office Appointments:

Please arrive promptly at the time of your appointment. Office appointments may be rescheduled if done so at least 48 hours before the scheduled appointment time. Appointments failed, cancelled or rescheduled with less than **48 hours** notice will be considered a failed appointment. Failed appointments will be billed a fee of **\$25**. Repeated failed appointments may be reason for dismissal from the practice.

Parking:

As a courtesy, patients will be provided one hour of parking validation on the day of their appointment. Patients must present their parking ticket to the receptionist to receive a one-hour validation sticker. Parking fees beyond one hour are the sole responsibility of the patient.

General Anesthesia / Sedation Services:

General anesthesia and sedation services require a deposit to reserve an appointment. General anesthesia and sedation appointments may be rescheduled if done so at least **seven (7)** business days before the appointment time. Appointments failed, cancelled or rescheduled with less than **seven (7)** business days notice will be considered a failed appointment. Failed appointments will forfeit the deposit amount and a new deposit will be required to reschedule.

Payment:

Payment is due in full at the time of service. _____ **initials**

If you have dental insurance we will as a courtesy provide an estimate of your benefits and a breakdown of your portion due. Please be aware that **THIS IS AN ESTIMATE ONLY**. Benefits may be different if your deductible has not been met, annual maximum has been met, if your coverage table is lower than average or if treatment changes occur. Patients are responsible for all co-pays and fees not covered by insurance. _____ **initials**

Payment may be in the form of CASH, CASHIERS CHECK, MONEY ORDER, VISA, MASTERCARD or CARE CREDIT. **No personal checks will be accepted.** _____ **initials**

Any balance due over 30 days will be submitted to a third party collections agency. _____ **initials**

SIGNATURE _____ DATE _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
Health Insurance Portability Accountability Act (HIPAA), 1996
<http://www.hhs.gov/ocr/hipaa/finalreg.html>

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Patient Name: _____

SECTION B: TO THE PATIENT/GUARDIAN - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, 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. Our Notice provides a description of our treatment, payment activities, and healthcare operations, and of the uses and disclosures we may make of your protected health information, and of other important 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: Capital Pediatric Dentistry, 920 29th St. Sacramento, CA 95816. (916) 476-3972

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 address 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 a personal representative on behalf of the patient signs this Consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

REVOCACTION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____

Acknowledgement of Receipt Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement that you have been notified that our *NOTICE OF PRACTICE POLICIES* can be obtained via our office. This document is printable via the web site for your records.

HIPAA website: <http://www.hhs.gov/ocr/hipaa/finalreg.html>

You May Refuse to Sign This Acknowledgement*

I have received acknowledgement of this office's Notice of Privacy Practices.

Signature: _____ **Date:** _____

For Office Use:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because: Individual refused to sign Communications barriers prohibited obtaining the acknowledgement An emergency situation prevented us from obtaining acknowledgement Other (Please Specify)



CAPITAL PEDIATRIC DENTISTRY

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Dental Treatment Consent Form for Preventive Procedures

Please read and initial all items below.

Patient Name: _____

Parent Name: _____

1. EXAM and CLEANING

Regular exams and cleanings play an important role in proper dental health. They allow the dentist to screen for dental caries, gingival and/or periodontal issues or orthodontic needs. A cleaning, fluoride treatment, x-rays and exam are performed. Risks include but are not limited to: sensitivity or bleeding of the teeth or gums due to scaling. I understand that if I choose not to maintain regular check-ups and/or cleanings, this decision may result in decay, pain, infection, and/or orthodontic or periodontal problems.

COMMENTS _____ Initial _____

2. X-RAYS

X-rays are used as an important diagnostic tool for the dentist. How often x-rays are taken depends on the age, risk for disease, and signs and symptoms of the patient. Our office follows the recommended guidelines from the FDA and the American Academy of Pediatric Dentistry. Many diseases of the teeth and surrounding tissues cannot be seen when your dentist examines your mouth visually. An x-ray may reveal the presence of small cavities between the teeth, infections in the bone, abscesses, cysts, developmental abnormalities and some types of tumors. It is in your child's best interest to be periodically screened with the use of diagnostic x-rays. Risks of not taking x-rays include but are not limited to: a failure to diagnose and treat conditions before signs and symptoms have developed than can threaten oral and general health. Risks from radiation exposure have been significantly reduced by improvements in technology. The benefits of dental x-rays to promote adequate and quick diagnosis outweigh the potential adverse effects. I understand if I choose to not allow x-rays to be taken, I may be asked to transfer my child to another dentist.

COMMENTS _____ Initial _____

3. SEALANTS

Sealant is a white material that is applied to the chewing surface of the molars and bicuspid where decay occurs most often. It acts as a barrier protecting the decay prone areas of the teeth. Grooves and depressions are difficult to keep clean because the toothbrush bristles do not reach into them. The sealant forms a thin covering that keeps food and plaque out, decreasing the chance of decay. The tooth is cleaned and conditioned to help the sealant adhere the chewing surface. The sealant is then painted on the tooth into the deepest pits and fissures. Risks include, but are not limited to: need for replacement, allergic reaction to the materials and/or possible decay if post operative instructions are not followed properly. I understand that my child may still get decay between his or her teeth even with sealants still intact. The alternative to sealants is to do nothing and decay may occur as a result of this decision.

Comments _____ Initial _____

I understand that dentistry is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and to ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Parent Signature _____ Date _____