

# Patient Information for a Minor Patient

Today's date: \_\_\_\_\_

Patient name (first, MI, last): \_\_\_\_\_

Patient's nickname: \_\_\_\_\_

Patient's primary residency:  Both parents  Mother  Father  Stepparent  Shared custody  Guardian

Address (street, city, state, ZIP): \_\_\_\_\_

Home phone: \_\_\_\_\_ Gender:  Male  Female

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

School: \_\_\_\_\_ Hobbies/sports: \_\_\_\_\_

Names and ages of other children in your family: \_\_\_\_\_

## Parent / Guardian Information

Name of responsible party (first, MI, last): \_\_\_\_\_

Date of birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Address (if different from patient), (street, city, state, ZIP): \_\_\_\_\_

Home phone: \_\_\_\_\_ Work phone: \_\_\_\_\_

Mobile phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

By providing your e-mail address you agree to receive (check one or both):  Appointment reminders  Practice newsletter

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work phone: \_\_\_\_\_

Work address (street, city, state, ZIP): \_\_\_\_\_

Name of financially responsible party, (if different from above), (first, MI, last): \_\_\_\_\_

Is financially responsible party the same as legal guardian?  Yes  No

Date of birth: \_\_\_\_\_ Relationship to patient (mother, father or other): \_\_\_\_\_

Address (if different from patient), (street, city, state, ZIP): \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_ Work phone: \_\_\_\_\_

Work address (street, city, state, ZIP): \_\_\_\_\_

## Dental Benefit Plan Information

Primary dental plan name: \_\_\_\_\_

Address (street, city, state, ZIP): \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of birth: \_\_\_\_\_

ID number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Patient relationship to insured: \_\_\_\_\_

Secondary dental plan name: \_\_\_\_\_

Address (street, city, state, ZIP): \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of birth: \_\_\_\_\_

ID number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Patient relationship to insured: \_\_\_\_\_

## Medical Plan Information

Plan name: \_\_\_\_\_

Address (street, city, state, ZIP): \_\_\_\_\_

Name of insured: \_\_\_\_\_ Date of birth: \_\_\_\_\_

ID number: \_\_\_\_\_ Policy number: \_\_\_\_\_

Patient relationship to insured: \_\_\_\_\_

# Authorizations for Responsible Party Form

We are committed to providing you and your child with the best possible care. Toward this goal, we would like to explain your financial and scheduling responsibilities with our practice.

**Payment:** Payment is due at the time services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment:

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**Please note:** If you elect to apply for third-party financing, administered through our practice, we are required by law to provide you with a Credit for Dental Services Notice.

**Dental Benefit Plans:** Your dental benefit is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and the plan. We are happy to help the parents and guardians of our patients with dental benefit plans to understand and maximize their coverage.

Our practice IS / IS NOT (circle one) a contracted provider with your dental benefit plan.

**If we are a contracted provider with your plan,** you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this and you will be responsible for the difference.

**If we are not a contracted provider with your dental benefit plan,** it is the insured's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if that amount is different than our estimated patient portion of the bill. If you choose to not "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental benefit plan and will be responsible for payment to our practice before or at the time of service.

**Scheduling of Appointments:** We reserve time on the schedule for each patient procedure and are diligent about being on-time. Because of this courtesy, when a patient cancels an appointment, it impacts the overall quality of service we are able to provide. To maintain the utmost service and care, we do require 48-hour notice to reschedule an appointment. With less than 48-hour notice, a fee of \$\_\_\_\_\_ or deposit to reserve the appointment time again, may be required. To serve all of our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, a fee of \$\_\_\_\_\_ or deposit to reserve the appointment time again, may be required.

**Authorizations:** I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that my child may need and have consented to during diagnosis and treatment. (initial) \_\_\_\_\_

I have read the above and agree to the financial and scheduling terms. (initial) \_\_\_\_\_

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me. YES / NO (Circle One) (initial) \_\_\_\_\_

I hereby acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice. (initial) \_\_\_\_\_

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. (initial) \_\_\_\_\_

**Signature of responsible party:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Confidential Medical & Dental History for a Minor Patient

Today's Date: \_\_\_\_\_

Patient Name (first, MI, last): \_\_\_\_\_ Date of birth: \_\_\_\_\_

## Medical History (Please circle Yes or No for each)

1. Physician's name: \_\_\_\_\_ Physician's phone: \_\_\_\_\_
2. Date of last medical examination? \_\_\_\_\_ Weight: \_\_\_\_\_
3. Patient is in good health? Yes / No If no, why? \_\_\_\_\_
4. Patient has regular medical exams? Yes / No
5. Patient is under the care of a physician at this time? Yes / No If yes, why? \_\_\_\_\_
6. Patient is up to date with immunizations? Yes / No
7. Patient is presently taking medications? Yes / No If yes, what and why? \_\_\_\_\_
8. Patient has allergies (medications, food, latex/rubber)? Yes / No If yes, what? \_\_\_\_\_
9. Patient has been hospitalized? Yes / No If yes, why and when? \_\_\_\_\_
10. Patient has had any operations? Yes / No If yes, why and when? \_\_\_\_\_
11. Patient has had general anesthesia? Yes / No
12. If yes, were there any complications? Yes / No If yes, please explain complications: \_\_\_\_\_

## Has the patient experienced, have or had any of the following? (Please circle Yes or No for each)

- |  |   |
|--|---|
| Yes / No Anemia  | Yes / No Heart defects                    |
| Yes / No Arthritis, rheumatism   | Yes / No Heart disease /defects / murmurs |
| Yes / No Artificial prosthesis, organs, joints, implants, shunts, valves | Yes / No Hepatitis                        |
| Yes / No Asthma  | Yes / No High blood pressure              |
| Yes / No Blood disorder  | Yes / No Jaundice                         |
| Yes / No Blurred vision  | Yes / No Joint pain or stiffness          |
| Yes / No Bone pain   | Yes / No Kidney or bladder disease        |
| Yes / No Canker or cold sores  | Yes / No Muscle pain, weakness            |
| Yes / No Chest pain, tightness, wheezing                                 | Yes / No Persistent cough or runny nose   |
| Yes / No Diabetes  | Yes / No Recent significant weight loss   |
| Yes / No Diarrhea or constipation  | Yes / No Rheumatic fever                  |
| Yes / No Ear infections  | Yes / No Seizures                         |
| Yes / No Eating disorders  | Yes / No Sexual transmitted disease       |
| Yes / No Excessive thirst  | Yes / No Shortness of breath              |
| Yes / No Eye disease   | Yes / No Skin disease                     |
| Yes / No Fainting spells   | Yes / No Spina bifida                     |
| Yes / No Family history of diabetes                                      | Yes / No Stomach problems or ulcers       |
| Yes / No Fever   | Yes / No Stroke                           |
| Yes / No Frequent urination  | Yes / No Thyroid disease                  |
| Yes / No Frequent vomiting   | Yes / No Transplants                      |
| Yes / No Headaches   | Yes / No Tuberculosis                     |
| Yes / No Hearing problems, ear pain                                      | Yes / No Tumors or cancer                 |
| Yes / No Heart attack  | Yes / No Urinary tract Infections         |

## This information will not be released unless specifically authorized by patient.

- |  |                     |
|--|---------------------|
| Yes / No Treatment for emotional, mental, or physical delays | Yes / No Anxiety    |
| Yes / No AIDS/HIV  | Yes / No Depression |

13. Does the patient have or has he/she had any other diseases or medical problems NOT listed on this form? Yes / No

14. If yes, explain: \_\_\_\_\_

15. Is there any issue or condition that you would like to discuss with the dentist in private? Yes / No

(dental history continued on next page)



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**FEES, PAYMENTS AND OFFICE POLICY**

We make every effort to keep down the cost of your dental care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental insurance, we will be glad to fill out the proper forms.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute for payment. Some companies pay a fixed allowance for certain procedures and others pay a percentage of the charge. It is **YOUR** responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company. You will be responsible for all collection costs, attorney's fees and court costs should collection action be necessary.

It is important to show up for scheduled appointments. This time has been reserved for you. **A fee will be charged for failed appointments.**

\_\_\_\_\_  
Signature of Patient  
(Parent or guardian if minor)

\_\_\_\_\_  
Date