SWEET TOOTH CHILDREN'S DENTISTRY
JULIA BROWN DDS

6331 Haven Ave., #12, Rancho Cucamonga, CA 91737
909-989-7222 (Office)• 909-989-7227 (Fax)
contactchildrensdentistry@gmail.com
sweettoothchildrensdentistry.com

Tell Us About Your Child

Today's Date_____

Child's Name:_____ Child's Birthdate:_____ Child's Age: _____
Last First MI

Nickname_____ Male ☐ Female ☐ School _____

Grade_____ Child's Home Address: _____

Who may we thank for referring you? _____

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

Is your child adopted or in foster care? ☐ Yes ☐ No Has any member of your family been or is currently a patient in this office? ☐ Yes ☐ No

If yes, name _____

Dental History

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

Has your child experienced problems with previous dental work? ☐ Yes ☐ No If yes, explain _____

Previous Dentist:_____ Date of Last Visit: _____

Why did you leave your previous dentist?_____

Medical History

Is your child under the care of a physician? ☐ Yes ☐ No Please explain: _____

Date of Last Visit:_____ _____ Phone(____) _____

If your child does not have a physician, where would you like them to have medical care?

_____

Does your child have Social/Personality/Temperament concerns that we should be aware of? _____

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

Please list all 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 (please check)

Abnormal Bleeding	☐ Y ☐ N	Any Operations	☐ Y ☐ N	Diabetes	☐ Y ☐ N	Heart Surgery	☐ Y ☐ N
Aids/HIV	☐ Y ☐ N	Asthma	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Hemophilia	☐ Y ☐ N
Allergies	☐ Y ☐ N	Breathing/Lung Problems	☐ Y ☐ N	Handicaps	☐ Y ☐ N	Hepatitis	☐ Y ☐ N
Anemia	☐ Y ☐ N	Congenital Birth Defect	☐ Y ☐ N	Behavior Learning Disabilities	☐ Y ☐ N	Lupus	☐ Y ☐ N
Any Hospital Stays	☐ Y ☐ N	Congenital Heart Defect	☐ Y ☐ N	Mentally/Physically Disabled	☐ Y ☐ N	Other	☐ Y ☐ N
Cancer/Tumors	☐ Y ☐ N	Hearing Impaired	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N		

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

Print Parent's Name_____ Parent's Signature_____ Date _____

Medical History Review:_____
Dentist's Signature Date

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Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single E-mail: _____

Father/Step Birthday_____/_____/_____ Home# (____)_____ Work# (____)_____ Cell# (_____) _____

Name:_____ Social Security #_____ Drivers Licence: _____

Employer:_____ Occupation:_____

Mother/Step Birthday_____/_____/_____ Home# (____)_____ Work# (____)_____ Cell# (_____) _____

Name:_____ Social Security #_____ Drivers Licence: _____

Employer:_____ Occupation:_____

Name of Parent who resides with child: _____

Nearest Relative:_____ Address:_____ Phone# _____

Insurance Information

Primary Insurance:

Insurance Company Name:_____ Phone#(_____) _____

Subscriber#_____ Group# _____

Insured Name:_____

Insured Company Address:_____

Secondary Insurance:

Insurance Company Name:_____ Phone#(_____) _____

Subscriber#_____ Group# _____

Insured Name:_____

Insured Company Address:_____

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to Julia Brown DDS Inc insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf of my dependants.

Signature:_____ Date: _____

Authorization and Release

To the best of my knowledge the information I have given on this form is correct and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Children's Dentistry to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and/or their health practitioners.

I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature:_____ Date: _____

Consent for Treatment

I hereby authorize and request the performance of dental service for my minor child. I understand that at the first appointment (examination, necessary x-rays, cleaning, topical fluoride) the doctor will explain my child's treatment needs and the various behavior management approaches. At this appointment the doctor's staff will review any associated fees. I also realize that any restorative treatment will be accomplished at a later date.

Signature:_____ Date:_____

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TO OUR PATIENTS AND FAMILIES

Thank you for choosing Children's Dentistry for your child's dental care. We consider families to be an essential participant in your child's care and wish to support and respect your needs while your child is under our care. We want you to understand your rights and responsibilities as families and patients at Children's Dentistry. Your signature on this form provides consent for treatment and payment, and acknowledges receipts of other general information. If you have questions, please ask your provider.

Missed/Broken Appointment(s)
Due to the limited space in our schedule and the need to provide timely service to all of our patients it is very important that you keep your scheduled appointments. It is understandable that occasionally you may need to reschedule due to an emergency or illness. We ask that you give us the courtesy of 24 hours notice so that we will have the opportunity to use your appointed time to provide treatment for others in need. If you arrive more than 15 minutes late to your appointment, this will require us to reschedule your appointment and will be counted as a missed/broken appointment. If you cancel your appointment without 24 hour notice, if you are more than 15 minutes late for your scheduled appointment, or if you "No-Show" for your appointment then you will be required to pay a $50.00 Non-Refundable Fee per child scheduled.

Insurance
Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 30 days the balance may be transferred to your account. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

All insurance co-pays and deductibles must be paid at the time of service.

AT THIS OFFICE WE FOLLOW THE GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY IN REGARD TO FREQUENCY OF X-RAYS, CLEANINGS, FLUORIDE TREATMENTS AND RESTORATIVE CARE. WE CONSIDER THESE GUIDELINES TO BE THE STANDARD OF CARE (BEST TREATMENT FOR YOUR CHILD). THESE GUIDELINES ARE NOT DICTATED BY DENTAL INSURANCE AND IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHETHER YOUR PARTICULAR INSURANCE PLAN WILL REIMBURSE YOU FOR THESE SERVICES. PLEASE CALL YOUR INSURANCE COMPANY WITH QUESTIONS REGARDING FREQUENCIES.

Print Patient's Name:_____ Date: _____

Parent's Signature:_____ Print Parent's Name: _____

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HIPAA NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and describe your protected health information (PHI) to carry out treatment, payment or healthcare operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information, that may identify you and relates to your past, present, or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay for your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate or manage your dental care and any related services. This includes the coordination or management of your dental care with a third party. For example, your protected health information may be provided to a specialist to whom you have been referred to ensure that the specialist has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used as needed, to obtain payment for your health care services. For example, obtaining approval for a restoration may require that your relevant protected health information be disclosed to the dental plan to obtain approval for the restoration.

Healthcare operations
We may use or disclose, as needed, your protected health information in order to support the business activities of our practice. These activities include, but are not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected information, as necessary, and to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease Health Oversight: Abuse or Neglect: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners Funeral Directors: and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Use and Disclosure: Under the law we must make disclosures to you and when required by Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 **Other Permitted and Required Uses and Disclosures** will be made only with your consent authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your dentist's practice has taken an action in reliance on the use or disclosure indicated in this authorization.

Your Rights
Following is a statement of your rights with respect to your protected health and information

- **You have a right to inspect and copy your protected health information.** Under federal law, however you may not inspect or copy the following records, psychotherapy notes: information compiled in reasonable anticipation of or use in a civil criminal or administrative action or proceeding and protected health information on that is subject to law that prohibits access to protected health information.
- **You have the right to request a restriction of your protected health information**. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purpose as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply: Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Health Professional.
- **You have the right to request to receive confidential communications from us by alternate means or at an alternative location.**
- **You have the right to obtain: a paper copy of this notice from us**, upon request, even if you have agreed to accept this notice alternatively i.e. Electronically.
- **You have the right to have your dentist amend your protected health information.** If we deny your request for amendment, you have the right to file a state of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- Y**ou have the right to receive an accounting of certain disclosures** we have made if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or the Secretary of Health and Human Recourses if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on or before September 1, 2008
We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information.

Signature/Relationship to Patient:_____ Print Your Name: _____

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Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability Accounting Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
Obtain payment from third party payers of my health care services.
Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental providers Notice of Privacy practices containing a more complete description of the uses and disclosers of my protected health and information. I have been given the right to review and receive a copy of such notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in the writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you agree then you are to abide by such restrictions.

Print Patient's Name:_____ Date: _____

Signature/Relationship to Patient:_____

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How can I best help my child during dental appointments?
Tips for parents of dental patients

Our goal at Sweet Tooth Children's Dentistry is for your child's dental appointment to be the highlight of their week! A dental visit can be a happy event for children especially if they are properly prepared. Our staff is fully trained and experienced in putting children at ease and eliminating discomforts of yesteryear. We see ourselves as your dental health guides, partnering with you as a team to keep your child healthy. We are excited to welcome you to the team!

Parent actions and comments that help children cooperate

1. Calm, relaxed, and upbeat parent attitude and body language. Happy facial expressions.
2. Play dentist with each other at home. You can take turns lying down and counting each other's teeth the week before the appointment so that they will know what to expect.
3. Bring something small that your child likes to the appointment such as a stuffed animal or small to
4. Planning a small reward for your child after a successful appointment.
5. Give the patient lots of praise afterwards with specific things that he/she did right like staying still, following directions and being a great listener.
6. Ask that siblings be cheerleaders for each other at their appointments.

Parent actions and comments that alarm children and interfere with cooperation

1. Stressed, hurried, or anxious parent attitude or body language.
2. Negative or scary stories and comments about dental treatment or appointments.
3. Confusing comments ("It's not going to hurt.")
4. Apology ("I'm sorry this is taking so long").
5. Suggestion to the dentist ("He does better when he knows what is going to happen").
6. Don't allow other family members to scare each other about coming to the dentist.

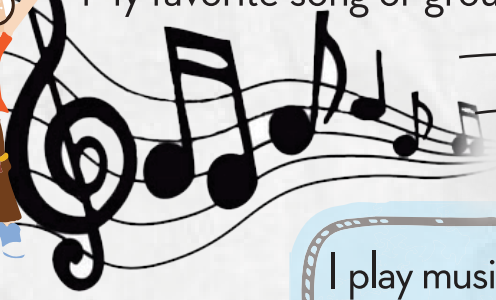
My name is: _____

I have a pet/pets named:
_____
_____
& he/she is a:
_____

My favorite food is:
_____
_____
_____
_____
_____
_____
_____
_____

My favorite color is:
_____

My favorite song or group is:
_____
_____



I am really good at:
_____
_____

I play musical instrument(s):
_____
_____
_____

What's your favorite class in school:
_____
_____
_____

I play sport(s):
_____
_____
_____

My favorite 

show or movie is:
_____
_____

One place I'd really like to go is:
_____
_____