PATIENT INFORMATION

Child's Name: ____ Nickname: _______________________________
DOB: __________/__________/__________ Age: _______________ ◯ Male ◯ Female
Address: ____

Parent/Guardian Information

Parent/Guardian Name: ___________________________________ Relationship to Patient: _____________________
DOB: __________/__________/__________ Email: ____
Home/Cell Phone: ____________________________________ 2nd Phone: ___________________________________

Parent/Guardian Name: ___________________________________ Relationship to Patient: _____________________
DOB: __________/__________/__________ Email: ____
Home/Cell Phone: ____________________________________ 2nd Phone: ___________________________________

Insurance Information

Dental Insurance: ______________________________________ SSN #/Member ID: ____________________________
Policy Holder's Name/Responsible Party: ____
Employer: ____ Job Title: ____________________________________

Secondary Insurance? ◯ Yes ◯ No
Dental Insurance: ______________________________________ SSN #/Member ID: ____________________________
Policy Holder's Name/Responsible Party: ____
Employer: ____ Job Title: ____________________________________

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have an authorization allowing this person to accompany your child. The person bringing your child will need to present a photo identification at time of service. If you choose to authorize a designated adult to accompany your child to their appointments, please fill out the section below or you can choose not to designate someone at this time.

Authorization for a Designated Adult to Accompany Patient

Name: ___________________________________Relationship to Patient: _______________________________
Home/Cell Phone: ______________________________ Email: ____

I authorize the above named to make any dental and medical decisions, including accompanying my child to clinic visits and consent to any changes in the treatment plan as they may arise at the time of the treatment, where the minor is not accompanied by either parents or legal guardians, and may not be feasible or practical to contact them. I agree to pay for my portion of the services provided to my child same day, if any, as the treatment is rendered.

◯ I do not wish to assign a designated adult to accompany my child to appointments at this time.

Parent/Guardian Name: _________________________________ **Patient Name:** ______________________________

Parent/Guardian Signature: ____ **Date:** __________________________

INFORMED CONSENT

Exams/X-rays/Fluoride Treatment

For the first visit and periodical exam, we perform comprehensive examinations, take necessary radiographs, and give fluoride treatments to ensure that our patients are in best oral health. The frequency of radiographs being taken depends on patient's oral hygiene and caries risk assessment. I understand that my child will be receiving a dental examination from Dr. Opinga and/or his staff members. I understand that x-rays may be taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

Dental Cleaning

I authorize Dr. Opinga and/or his staff members to clean my child's teeth today.

Medical Photography Consent

I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purposes of identification and dental treatment.

Drugs and Medication

I understand that antibiotics, analgesics, and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

Optional Photography Consent

I consent to having my child's photo taken and displayed in the office as part of contests or bulletin boards.
◯ I consent ◯ I do not consent

I consent to having my child's photo taken and posted as part of online social media including, but not limited to: the office website and blog; Facebook, Yelp and Instagram.
◯ I consent ◯ I do not consent

Authorization and Release

I hereby certify that I have read and understand the consent form. I affirm that that 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 change in my personal contact information and the medical status of my child. I authorize the dental team to perform the necessary dental service my child need including, but not limited to, examination, prophy, radiographs, and fluoride treatment. I hereby certify that I understand and have been informed of the risks, benefits, and alternatives of the provided dental procedures.

Parent/Guardian Name: ______________________ **Patient Name:** ______________________

Parent/Guardian Signature: ______________________ **Date:** ______________________

FINANCIAL POLICY

Although our office will gladly e-file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility. You are required to provide your most current insurance information prior to every visit and as needed throughout care. Insurance plans can vary greatly, and some companies arbitrarily select certain services that they will not cover. I authorize Bethel Kids Dental to collect payment from the insurance company. I understand that the insurance company may reimburse only a portion of my bill and that I am ultimately responsible for the full payment. If the insurance company denies a claim for any reason at any time, I understand that I am directly responsible for the payment of the outstanding amount. Please contact us if you make any changes to your dental coverage, so that we may keep accurate and current records of your account. If after 60 days the insurance company has not paid on the claim, I understand I am fully responsible for the total unpaid balance. A member of our Billing Department will notify you if there's any unpaid balance in your account. We understand that many can experience financial difficulties at any moment in time. If this is the case, please contact our Billing Department so that we may assist you in making payment arrangements. Bethel Kids Dental accepts Cash or Credit Card payments only. __________ (INITIALS)

UNPAID/UNCOLLECTED BALANCE

Any unpaid and uncollected balances beyond 90 days will be referred to an outside collection agency after notice of non-payment and balance due is sent. In the event that your account is turned over for collections, the responsible party agrees to pay all additional fees incurred in the collection of the debt. These fees include the balance and any fees associated in collecting the payment and attorney's fees. During this time, we will not be able to see your kids for additional services in our office until the unpaid/uncollected balance is paid or payment arrangements is made. __________ (INITIALS)

TERMS OF PAYMENT FOR SELF-PAY

In the event that you do not have health insurance, or you know in advance that a specific service will not be covered by your insurance company, you will be responsible for making a payment prior to rendering services during that day at our office. You need to pay the full amount at each visit. __________ (INITIALS)

MEDI-CAL DENTAL INSURANCE

Our office is a Medi-Cal Dental participating provider and we will bill Medi-Cal Dental for you. You are required to present a valid Benefit Issuance Card (BIC) at every visit and as needed. If you do not have a BIC card at the time of the visit, you are responsible to request a new or replacement card. If we do not have a valid BIC card or eligibility on file, you will be responsible for any fees that are left unpaid or not paid by Medi-Cal Dental. In the instance that Medi-Cal Dental has not paid within 90 days of filing the claim or paid less than anticipated for care, one of our team members will communicate with you regarding the situation. __________ (INITIALS)

REQUESTING A NEW BIC OR REPLACEMENT BIC CARD (FOR MEDI-CAL DENTAL INSURANCE)

If you did not receive your card, lost your card, your card was stolen, or the card you received in the mail has the wrong information on it, you may ask for a BIC from your local county social services office. For San Joaquin County, you may call and ask for a Benefit Identification Card (BIC) by contacting the BIC Issuance Desk at 209-468-1328. __________ (INITIALS)

I assume financial responsibility for all dental treatment and medications provided for my child. I understand that payment is expected on the date services are provided. I have read, understood, and agreed to the above financial policy for payments of rendered service(s) to our office.

Parent/Guardian Name: ______________________________ Patient Name: ______________________________

Parent/Guardian Signature: ______________________________ Date: ______________________

OFFICE POLICIES

Parent/Guardian Policy

I acknowledge that the policy of Bethel Kids Dental is for a legally responsible parent or guardian to be present for all dental appointments. If someone other than the parent or legal guardian accompanies your child to their visit, they must have a signed parental authorization/consent on file, or we reserve the right to reschedule the appointment.

Cancellation and No Shows

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, we require at least a 24-hour advanced notice. This courtesy makes it possible to give your reserved room to another patient who would like it. Repeated cancellations with a maximum of three missed appointments without notice will result in loss of future appointment privileges. We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We, of course, would appreciate the same courtesy from you. If you have any questions or issues that are preventing you from keeping your appointments, please call us ahead of time at (209) 400-2018 and we will gladly reschedule your appointment to a more convenient time.

HIPAA Acknowledgement

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices. I understand and consent to my child's medical information being used within the guidelines of The Health Insurance Portability and Accountability Act (HIPAA). I understand the terms and authorize Bethel Kids Dental to disclose my child's dental information to practitioners involved in my child's care and parties I authorize to receive my child's dental information.

Dental Materials Fact Sheet

Copies of the Dental Materials Fact Sheet, dated May 2004, are in the kiosk at front desk and are available to pick up anytime.

Parent/Guardian Name: ______________________________ **Patient Name:** ______________________________

Parent/Guardian Signature: ______________________________ **Date:** ____________________

ARBITRATION AGREEMENT

Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

All Claims Must Be Arbitrated: It is the intention and agreement of the parties that this arbitration agreement shall cover all claims or controversies relating to the matters described in Article 1 above, except claims within the jurisdiction of the Small Claims Court, whether in tort (intentional or negligent), contract, or otherwise, including but not limited to suits relating to the matters described in Article 1 and also involving claims for loss of consortium, wrongful death, discrimination, emotional distress or punitive damages. Arbitration pursuant to the terms of this Contract shall bind all parties whose claims as described above may arise out of or in any way relate to treatment or services provided or not provided by Bethel Kids Dental or any employee or agent or providers of Bethel Kids Dental, including any spouse or heirs of Patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. The undersigned understands and agrees that if the undersigned signs this Contract on behalf of some other person for whom the undersigned has responsibility, then, in addition to the undersigned, such person(s) will also be bound, along with anyone else who may have a claim arising out of the treatment or services rendered to that person. The reference to Bethel Kids Dental includes the corporation, and its employees, agents and providers. Filing any action in any court by Western to collect any fee from Patient shall not waive the right to compel arbitration of any claim described above. However, following the assertion of any claim against Bethel Kids Dental, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by the same arbitration.

Procedures and Applicable Law: Patient shall initiate arbitration by serving a Demand for Arbitration on Bethel Kids Dental and each defendant. The claim shall be mailed by U.S. mail, postage prepaid, to: Bethel Kids Dental, 531 W. Kettleman Lane, Lodi, CA 95240. A Demand for Arbitration must be communicated in writing to all parties, identify each defendant, describe the claim against each party, and the amount of damages sought, and the names, addresses and telephone numbers of the Patient and his/her attorney. Patient and Bethel Kids Dental agree that any arbitration hereunder shall be conducted by a single, neutral arbitrator selected by the parties and shall be resolved using the rules of the American Arbitration Association. (Arbitration, however, shall not be conducted by the American Arbitration Association.) Patient shall pursue his/her claims with reasonable diligence, and the arbitration shall be governed pursuant to Civil Code §§ 3333.1 and 3333.2, Code of Civil Procedure §§ 340.5, 667.7, 1281-1295 and the Federal Arbitration Act (9 U.S.C. §§ 1- 9), as in effect from time to time.

Retroactive Effect: Patient intends this Contract to cover services rendered by Bethel Kids Dental not only after the date it is signed (including, but not limited to, emergency treatment), but also before it was signed as well.

Severability: If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this Contract. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

Parent/Guardian Name: ________________________________ **Patient Name:** ______________________________

Parent/Guardian Signature: ____ **Date:** _________________________

HEALTH HISTORY FORM

Dental History

◯Yes ◯No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) ______________________________

◯Yes ◯No Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain: ______________________________

◯Yes ◯No Does your child suck a finger, thumb, or pacifier (please circle)? If yes, when? ______________________________

◯Yes ◯No Does your child go to bed with a bottle or sippy cup? If yes, what is in it? ______________________________

◯Yes ◯No Does your child snack frequently? What are their favorite snack foods? ______________________________

◯Yes ◯No Has your child had local anesthetic? If yes, were there any problems? ______________________________

◯Yes ◯No Has your child ever been sedated for dental treatment? If yes were there any problems?______________________

◯Yes ◯No Have your child's teeth ever been injured? Which teeth: ______________________________

◯Yes ◯No Has your child or anyone in your immediate family ever had a cold sore or other mouth ulcer? Please describe: ______________________________

◯Yes ◯No Does your child use a fluoride toothpaste?

◯Yes ◯No Does your child begin to smoke cigarettes or use any tobacco products?

Please check if your child is having problems with any of the following:

◯Cavities ◯Color of Teeth ◯Grinding of Teeth ◯Gum Infections ◯Jaw Sounds

◯Mouth Breathing ◯Orthodontics ◯Sensitive Teeth ◯Trauma ◯Toothache

Other: ______________________________

Medical History

Child's Physician/Pediatrician: ______________________________ Phone: ______________________________

◯Yes ◯No Is your child in good health? Date of last physical exam: ______________________________

◯Yes ◯No Has your child ever had a health problem? ______________________________

◯Yes ◯No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: ______________________________

◯Yes ◯No Is your child currently taking any medications? Please give medication, dose, and reason: ______________________________

◯Yes ◯No Is your child allergic to any medications? Any food? If yes, please list what medication and/or food: ______________________________

◯Yes ◯No Are your child's immunizations current?

◯Yes ◯No Have you ever been told that your child needs to take antibiotics before dental treatment?

Please check if your child has been treated for any of the following:

◯Abuse ◯Cancers/Tumors ◯Heart Murmurs ◯Sickle Cell Disease

◯ADHD ◯Cerebral Palsy ◯Hepatitis ◯Significant Injuries

◯Adverse Drug Reaction ◯Congenital Birth Defect ◯HIV/AIDS ◯Snoring

◯Anemia ◯Diabetes ◯Liver/GI Disease ◯Speech/Hearing Issues

◯Asthma/Breathing Problems ◯Endocrine/Growth Problems ◯Mental Delays ◯Spina Bifida

◯Autism ◯Eyesight Problems ◯Personality Problems ◯Tonsil Problems

◯Blood Transfusion ◯Frequent Infections ◯Recurrent Headaches ◯Tuberculosis

◯Blood Disorders ◯Heart Disease ◯Seizures

Other: ______________________________

To the best of my knowledge, the questions on this form have been accurately answered. 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.

Parent/Guardian Name: ______________________________ **Patient Name:** ______________________________

Parent/Guardian Signature: ______________________________ **Date:** ______________________________