



531 W. Kettleman Lane
Lodi, CA 95240
Tel: 209-400-2018

1660 W. Yosemite Ave. #1
Manteca, CA 95337
Tel: 209-500-1910

3633 Bradshaw Rd. #A
Sacramento, CA 95827
Tel: 916-810-2025

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: _____

Designated Adult Information

Name: _____ DL/Valid ID#: _____
Cellphone: _____ Email: _____
Relationship with Patient: _____

Emergency Contact (If parents are not available): _____

Cellphone: _____ Email: _____

- I, the undersigned, hereby authorize the designated adult named above to accompany my minor child during dental appointments at Bethel Kids Dental and provide any necessary verbal or written consents regarding dental procedures, treatments, or decisions on my behalf.
- This authorization grants the designated adult the ability to accompany the minor child to dental appointments, discuss treatment plans, and make decisions if required.
- The designated adult authorized to sign consent for any dental procedures or treatment decisions during the appointment without prior consultation with me, the legal guardian.

This authorization will be valid for dental appointments until revoked in writing.

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:

- | | | | | |
|---------------------------------------|--------------------------------------|---|--------------------------------------|----------------------------------|
| <input type="radio"/> Cavities | <input type="radio"/> Color of Teeth | <input type="radio"/> Grinding of Teeth | <input type="radio"/> Gum Infections | <input type="radio"/> Jaw Sounds |
| <input type="radio"/> Mouth Breathing | <input type="radio"/> Orthodontics | <input type="radio"/> Sensitive Teeth | <input type="radio"/> Trauma | <input type="radio"/> 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 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:

- | | | | |
|---|---|--|---|
| <input type="radio"/> Abuse | <input type="radio"/> Cancers/Tumors | <input type="radio"/> Heart Murmurs | <input type="radio"/> Sickle Cell Disease |
| <input type="radio"/> ADHD | <input type="radio"/> Cerebral Palsy | <input type="radio"/> Hepatitis | <input type="radio"/> Significant Injuries |
| <input type="radio"/> Adverse Drug Reaction | <input type="radio"/> Congenital Birth Defect | <input type="radio"/> HIV/AIDS | <input type="radio"/> Snoring |
| <input type="radio"/> Anemia | <input type="radio"/> Diabetes | <input type="radio"/> Liver/GI Disease | <input type="radio"/> Speech/Hearing Issues |
| <input type="radio"/> Asthma/Breathing Problems | <input type="radio"/> Endocrine/Growth Problems | <input type="radio"/> Mental Delays | <input type="radio"/> Spina Bifida |
| <input type="radio"/> Autism | <input type="radio"/> Eyesight Problems | <input type="radio"/> Personality Problems | <input type="radio"/> Tonsil Problems |
| <input type="radio"/> Blood Transfusion | <input type="radio"/> Frequent Infections | <input type="radio"/> Recurrent Headaches | <input type="radio"/> Tuberculosis |
| <input type="radio"/> Blood Disorders | <input type="radio"/> Heart Disease | <input type="radio"/> Seizures | |

Other: _____

Does your child have any allergies?

- Medication(s) Latex Anesthetics Bisphosphonate Food

Please specify: _____

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.

Patient Name: _____ **DOB:** _____

Parent/Guardian Signature: _____ **Date:** _____



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BETHEL KIDS DENTAL OFFICE POLICIES

Parent/Guardian Policy

At Bethel Kids Dental, a legally responsible parent or guardian must be present for all dental appointments. If someone other than the parent or legal guardian accompanies your child, a signed parental authorization/consent form must be on file. If this requirement is not met, we reserve the right to reschedule the appointment.

Parents or guardians must remain on the premises during their child’s dental exam or treatment. Leaving the child unattended in the office or arranging for pickup via a ride-sharing service is strictly prohibited. Unaccompanied children will only be released to the parent or legal guardian on file.

If a child is left unattended, the office will not assume responsibility for their supervision, and the parent/guardian waives all liabilities for any incidents occurring in their absence. If a parent or guardian is unreachable after multiple contact attempts, the office will notify the appropriate local authorities for further instructions.

Appointment Cancellations & No-Shows

When you schedule an appointment, we reserve a treatment room, prepare your child’s records, and set up specialized instruments. To ensure efficient scheduling and availability for other patients, we ask that you provide at least 24 hours’ notice if you need to reschedule or cancel an appointment.

Repeated missed appointments without proper notice (maximum of three no-shows) may result in loss of future appointment privileges. If you anticipate difficulty keeping an appointment, please call us in advance at (209) 400-2018, and we will gladly reschedule to a more convenient time.

Requesting a New or Replacement BIC Card (For Medi-Cal Dental Insurance)

If you have lost your Benefit Identification Card (BIC), did not receive it, or received a card with incorrect information, you can request a new one through your local county social services office.

For San Joaquin County, you can request a replacement BIC by contacting the BIC Issuance Desk at (209) 468-1328.

For Sacramento County, you can contact the BIC Issuance Desk at (916) 874-2072.

HIPAA Notice of Privacy Practices – Acknowledgment, Consent, and Authorization

I acknowledge that I have received a copy of the HIPAA Notice of Privacy Practices. I understand and consent to the use of my child’s medical information in accordance with the Health Insurance Portability and Accountability Act (HIPAA).

I authorize Bethel Kids Dental to disclose my child’s dental records to practitioners involved in their care and to any authorized parties I designate.

Dental Materials Fact Sheet

I acknowledge that I have received a copy of the Dental Materials Fact Sheet (May 2004) and understand the information provided.

Patient Name: _____ DOB: _____

Parent/Guardian Signature: _____ Date: _____

INFORMED CONSENT FOR DENTAL EXAMINATION

We are committed to providing the highest standard of dental care for your child. Please read the following consent carefully and acknowledge your agreement by signing below.

Examinations, X-Rays, Dental Cleaning (Prophylaxis), and Fluoride Treatment

Regular dental exams, necessary radiographs (X-rays), and fluoride treatments are essential for maintaining optimal oral health. The frequency of X-rays depends on your child's oral hygiene and risk of cavities.

- I understand and consent that my child will receive a dental examination by one of our dentists. I acknowledge that X-rays may be taken as part of a thorough and comprehensive examination to assess my child's oral health.
- I authorize Bethel Kids Dental to clean my child's teeth, including the removal of plaque, tartar, and surface stains, to help maintain oral health and prevent cavities and gum disease.
- I understand that fluoride is a preventive treatment used to strengthen tooth enamel and reduce the risk of cavities. Although adverse reactions are rare, excessive ingestion of fluoride may cause temporary nausea.

Drugs and Medications

I understand that antibiotics, analgesics, and topical compounds may be prescribed or administered as necessary for my child's dental treatment. I acknowledge that medications can cause allergic reactions, including but not limited to redness, swelling, itching, rash, vomiting, and, in rare cases, anaphylactic shock.

I affirm that I have informed the dentist, to the best of my knowledge, of any allergies or adverse reactions my child has experienced with medications.

Medical Photography Consent

I consent to digital photographs and X-ray images of my child being taken for documentation in their dental records, for diagnosis and treatment planning, and for submission to insurance providers as needed.

Optional Photography Consent

I consent I do not consent to my child's photo being taken and displayed within the office for contests, bulletin boards, or educational purposes and to my child's photo being shared online for promotional purposes, including but not limited to the office website, blog, social media platforms (Facebook, Instagram, Yelp, etc.).

Potential Risks and Limitations

I understand that, as with any dental procedure, there are potential risks involved, including but not limited to:

- Temporary tooth sensitivity or discomfort after cleaning or fluoride application.
- Possible gagging or discomfort during X-rays.
- Allergic reactions or side effects from medications or topical treatments.
- The need for additional dental procedures if issues are detected during the examination.

Parent/Guardian Responsibilities

- I agree to provide accurate and updated medical and contact information for my child.
- I understand that it is my responsibility to follow home care recommendations and schedule follow-up visits as needed.
- I acknowledge that failure to address dental issues in a timely manner may lead to more serious oral health problems requiring extensive treatment.

Authorization and Release

I have read and understand the above consent form. I confirm that the information I have provided is accurate to the best of my knowledge. I authorize Bethel Kids Dental to perform the necessary dental procedures for my child, including but not limited to examinations, X-rays, cleanings, and fluoride treatments.

I understand that I have the right to ask questions and receive additional information regarding my child's dental care.

Patient Name: _____ DOB: _____

Parent/Guardian Signature: _____ Date: _____

FINANCIAL POLICY

Bethel Kids Dental is committed to providing high-quality dental care to your child. This Financial Policy outlines your obligations regarding payment for services. By signing below, you acknowledge and agree to the following terms and conditions.

1. Insurance Coverage and Financial Responsibility

- Dental insurance, including Medi-Cal Dental, is a contract between you (the subscriber) and your insurance carrier. Bethel Kids Dental is not a party to this contract.
- As a courtesy, we will submit claims to your insurance carrier and/or Medi-Cal Dental; however, we do not guarantee payment or coverage of services.
- You are financially responsible for all charges incurred for services provided to your child, except where prohibited by applicable law, including but not limited to deductibles, co-payments, co-insurance, non-covered services, and denied claims.
- If your insurance carrier does not remit payment within thirty (30) days of claim submission, the outstanding balance may become the responsibility of the parent/guardian.
- You are responsible for providing accurate and current insurance information and must notify our office immediately of any changes in coverage or eligibility.

2. Coordination of Benefits (Dual Coverage):

- When a patient is covered by more than one dental plan, claims must be processed in accordance with coordination of benefits rules.
- The primary insurance carrier must be billed first.
- If Medi-Cal Dental is secondary, it will only be billed after the primary insurance has processed the claim and will only consider eligible remaining balances.
- The order of claims is determined by insurance regulations and cannot be altered, reassigned, or bypassed.

3. Medi-Cal Dental (Denti-Cal) Policies

- We are contracted with Medi-Cal Dental to provide dental services, but not all treatments may be covered.
- You are responsible for keeping your child's Medi-Cal Dental eligibility and Benefit Identification Card (BIC) up to date and a valid BIC must be on file. **For replacement BIC cards:** San Joaquin County: (209) 468-1328 or Sacramento County: (916) 874-2072
- If eligibility cannot be verified at the time of service, services may be rescheduled or the parent/guardian may elect to proceed as a cash-paying patient.
- If Medi-Cal Dental denies a claim or the service is not covered, you are responsible for payment.

4. Non-Covered and Elective Services

- Certain services may not be covered by your insurance plan or Medi-Cal Dental.
- You will be informed in advance of any known non-covered services and associated costs.
- By proceeding with treatment, you agree to be financially responsible for those services, unless otherwise restricted by law.

5. Appointment Policy

- A minimum of twenty-four (24) hours' notice is required to cancel or reschedule an appointment.
- Missed or late-cancelled appointments may result in a fee, as permitted by law, and may affect future scheduling privileges.

6. Payment Arrangements

- If you are unable to meet your financial obligations, you must contact our office prior to the due date.
- Payment plans may be offered at the sole discretion of Bethel Kids Dental and must be agreed upon in writing.

7. Accepted Forms of Payment

- We accept: Cash, Credit Card (Visa, MasterCard, American Express, Discover), Debit Card, and Check.

8. HIPAA Compliance

- Your child's protected health information will be used and disclosed in accordance with the Health Insurance Portability and Accountability Act (HIPAA) for purposes of treatment, payment, and healthcare operations.

9. Assignment of Benefits and Authorization

By signing below, you:

- Authorize direct payment and/or assignment of insurance and/or Medi-Cal Dental benefits to Bethel Kids Dental.
- Authorize release of necessary information for claim processing.
- Agree to be financially responsible for charges not paid by insurance, except as limited by applicable law.

Acknowledgment and Agreement

I certify that I am the parent or legal guardian of the patient and have read, understand, and agree to the terms of this Financial Policy. I acknowledge financial responsibility in accordance with applicable California and federal laws.

Patient's Name: _____ DOB: _____

Parent/Guardian Name & Signature: _____ Date: _____