Bethel Kids DENTAL

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: _____

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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.

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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.

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

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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.

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

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FINANCIAL POLICIES

We are committed to providing you with the best possible dental care and we want to help you understand the financial policies related to your treatment. Please take the time to review and acknowledge our financial policies.

1. Insurance Coverage
   - Your dental insurance coverage is a contract between you and your insurance company. We are not a party to this contract.
   - We will file a claim with your dental insurance as a courtesy, but we cannot guarantee that your insurance will pay for the services provided.
   - You are responsible for any charges not covered by your insurance plan, including deductibles, co-payments, co-insurance, and any balance not covered by your insurance.
   - If your insurance company does not respond within 30 days, you are responsible for the total balance of your dental treatment.
2. Insurance Verification
   - We will make every effort to verify your insurance coverage and inform you of your estimated co-payment, but the information received from your insurance company is not a guarantee of payment.
   - It is your responsibility to notify us of any changes in your insurance policy or coverage. Please provide us with the updated information promptly.
3. Payment Responsibilities
   - Any balance remaining after your insurance payment is due upon receipt of the billing statement. Payment is expected within 30 days.
   - We accept payments by cash, credit card (Visa, MasterCard, American Express, Discover), and debit cards.
   - If your insurance does not cover the full treatment cost, you are responsible for the remaining balance.
4. Co-Payment & Deductibles
   - Co-payments are due at the time of service.
   - If you have a deductible, you will be responsible for paying it directly to us before or at the time of service.
5. Non-Covered Services
   - If your treatment is not covered by insurance, you will be responsible for the full cost of those services. Please inquire about the fees before the procedure if you are uncertain about your coverage.
6. Missed Appointments
   - A charge may be applied for missed appointments or for appointments canceled without 24-hour notice.
7. Collection of Payment
   - In the event that payment is not made and the balance is not paid in full, we may need to send the balance to collections. You will be responsible for any collection fees incurred as a result of your unpaid balance.
8. Financial Assistance
   - We offer payment plans for certain procedures that are not covered by insurance or for patients without insurance. Please speak with our office staff to discuss payment options if needed.

ASSIGNMENT OF BENEFITS

By signing below, I assign all insurance benefits, if applicable, directly to Bethel Kids Dental for services rendered. I authorize the release of any necessary information to my insurance company to process my claims. I understand that I am financially responsible for any balance not covered by insurance.

ACKNOWLEDGEMENT OF RECEIPT AND AGREEMENT

I, the undersigned, acknowledge that I have read and understand the financial policies stated above, including the Assignment of Benefits. I agree to abide by the terms and conditions outlined in this agreement and accept responsibility for any balance due after my dental insurance has been processed.

Patient Name: _____ **DOB:** _____

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