Specialists in Dentistry for Children
Marilou Navarro DDS & Associates Inc.
750 N. Capitol Ave. Suite C2 San Jose, CA, 95133-1942
Tel: (408) 258-5244 Fax: (408) 213-5667
Email: dentistry4kids@sbcglobal.net Website: dentistry4kids.us

NEW PATIENT PAPERWORK

Patient Information

Patient Full Name: _____ Nickname: _____ Biological Sex: ☐ Female ☐ Male
Today's Date: _____/_____/_____ Patient Date of Birth: _____/_____/_____ Patient Age: _____
Home Phone #: (____) _____-_____ Cell Phone #: (____) _____-_____ Email: _____
Home Address: _____ City: _____ State: _____ Zip Code: _____
Do you have any family/relatives as patients at this practice? ☐ Yes ☐ No If yes, who: _____
How did you hear about us? ☐ Internet, where? _____ ☐ Referral, whom? _____

Dental History

What is the primary reason for today's visit? _____
Is the patient currently in pain? ☐ Yes ☐ No Is this the patient's first time seeing a dentist? ☐ Yes ☐ No
Has the patient experienced problems with previous dental work/visits? ☐ Yes ☐ No ☐ N/A **(If N/A, please skip the NEXT THREE lines)**
Dentist Name: _____ Date of Last visit: _____/_____/_____ Date of Last X-rays: _____/_____/_____
Dentist Phone #: (____) _____-_____ Dentist Fax #: (____) _____-_____ Dentist Email: _____
Dentist Address: _____ City: _____ State: _____ Zip Code: _____
Have there been any injuries to the patient's teeth, jaws, falls, blows, chips, etc. ☐ Yes ☐ No
Does the patient take fluoride supplements? ☐ Yes ☐ No
Does the patient brush their teeth? ☐ Yes ☐ No If yes, how many times a day? _____
Does the patient eat snacks/sweets/juice in-between meals? ☐ Yes ☐ No If yes, how many times a day? _____

Please check all that apply to the patient:

☐ Lip sucking and Nail biting	☐ Clenching/Grinding teeth	☐ Tongue/Cheek biting	☐ Mouth breather
☐ Chewing on Objects	☐ Thumb/Finger sucking	☐ Used Pacifier	☐ Speech problems
☐ TMJ/TMD pain	☐ Nursing Bottle habits	☐ Tongue thrusting	☐ Breast fed
☐ Snoring			

Medical History

Primary Care Physician (PCP): _____ Date of Last visit: _____/_____/_____ PCP Phone #: (____) _____-_____
PCP Fax #: (____) _____-_____ PCP Email: _____ Medical Insurance Name: _____
PCP Address: _____ City: _____ State: _____ Zip Code: _____
Is the patient under the care of PCP? ☐ Yes ☐ No If yes, please explain: _____
Does the patient have any social/personality/temperament concerns we should be aware of? ☐ Yes ☐ No
Please describe the patient's current physical health: ☐ Good ☐ Fair ☐ Poor
Please list all medications (with dosage) the patient is currently taking: _____
Please list all the patient's allergies: _____
Is there anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Please check all that apply to the patient

Abnormal bleeding	☐ Y ☐ N	Breathing/Lung Problem	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Mononucleosis	☐ Y ☐ N
AIDS/HIV	☐ Y ☐ N	Congenital Birth Defect	☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Rheumatic	☐ Y ☐ N
Allergies	☐ Y ☐ N	Congenital Heart Defect	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Scarlet fever	☐ Y ☐ N
Anemia	☐ Y ☐ N	Diabetes	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Seizures	☐ Y ☐ N
Any Hospital Stays	☐ Y ☐ N	Endocrine System Disorder	☐ Y ☐ N	Hives	☐ Y ☐ N	Sickle Cell Anemia	☐ Y ☐ N
Any Operations	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N	Sight Disorders	☐ Y ☐ N
Asthma	☐ Y ☐ N	Frequent Headaches	☐ Y ☐ N	Liver/GI System Problems	☐ Y ☐ N	Significant Injuries	☐ Y ☐ N
Autism	☐ Y ☐ N	Frequent Infections	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Skin Rash	☐ Y ☐ N
Blood Dyspraxia	☐ Y ☐ N	Behavior/Learning Disorder	☐ Y ☐ N	Lupus	☐ Y ☐ N	Sleep Apnea	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Mentally/Physically Disabled	☐ Y ☐ N	Measles	☐ Y ☐ N	Tonsillitis	☐ Y ☐ N
Cancer/Tumor	☐ Y ☐ N	Handicaps	☐ Y ☐ N	Mitral Valve Prolapsed	☐ Y ☐ N	Tuberculosis	☐ Y ☐ N
Chicken Pox	☐ Y ☐ N	Hearing Impaired	☐ Y ☐ N	**Other medical problems not listed above:** _____			

Name: _____ Relationship to patient: _____ Signature: _____ Date: _____/_____/_____

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Parent/Legal Guardian Information

Patient lives with: ☐ Mother ☐ Father ☐ Both Parents (Same Household) ☐ Both Parents (Separate Households) ☐ Self **(If Self, please skip this whole section)** ☐ Other: _____

Full Name: _____ Relationship to patient: _____ Biological Sex: ☐ Female ☐ Male

Date of Birth: _____/_____/_____ Social Security #: _____ Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Cell Phone #: (____) _____-_____ Work Phone #: (____) _____-_____ Email: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Employer Name: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Dental Insurance Name: _____ Member ID #: _____ Group No: _____ Dental Insurance Phone #: (____) _____-_____

Dental Insurance Address: _____ City: _____ State: _____ Zip Code: _____

Full Name: _____ Relationship to patient: _____ Biological Sex: ☐ Female ☐ Male

Date of Birth: _____/_____/_____ Social Security #: _____ Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Cell Phone #: (____) _____-_____ Work Phone #: (____) _____-_____ Email: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Employer Name: _____ Occupation: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

Dental Insurance Name: _____ Member ID #: _____ Group No: _____ Dental Insurance Phone #: (____) _____-_____

Dental Insurance Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Information

Please provide a name, number, and email of a friend, neighbor, relative, etc. (not listed above) who we may contact in the event of an emergency.

Name: _____ Phone #: (____) _____-_____ Email: _____

Disclosures

Dental Insurance: As a courtesy, we will assist you in obtaining reimbursement from your dental insurance carrier. However, responsibility for payment of services and collections of disputed insurance claims lies with you.

Release of Information: You authorize this office to release dental radiographs (x-rays) if requested by another practice.

Office Policy: We require payment for dental services at the time they are rendered unless other plans have been made in advance. Should you need other financial arrangements, our front desk coordinators can discuss payment plans with you. All accounts over 60 days delinquent may receive a 2% service charge per month.

Broken Appointments: You will be charged a $50.00 late cancellation/no-show fee, unless you notify our office at least 48 hours or two days before the scheduled appointment via text, call, or email.

Consent for Treatment: You understand that at the first appointment (i.e., examination, necessary x-rays, cleaning, and topical fluoride), the doctor will explain any treatment and various behavior management approaches needed for the patient. The treatment coordinator will review any associated fees at the day of the appointment. You are aware that any restorative treatment will most likely be accomplished at a later date. You, hereby, authorize and request performance of dental services and procedures for the patient that the dentists at Marilou Navarro DDS and Associates Inc. may dictate during treatment and after initial discussions with you.

Patient Expectations: You acknowledge full responsibility for the payments towards Marilou Navarro DDS and Associates Inc., and agree that you will take responsibility for any and all costs incurred by your failure to remit for services rendered. You have given any and all information truthfully, and accept full responsibility for any inaccuracies. You ought to update our office of any information changes in the future.

Dental Materials Fact Sheet: Pursuant to California State law, you have been given a copy of the Dental Materials Facts Sheet to read. You have had the opportunity to discuss this information and ask questions. You will receive a copy of the Fact Sheets upon your request.

Consent to Contact

You are allowing our practice to contact you regarding appointments, treatments, insurances, financials, and office updates when necessary via **(Please check boxes)** ☐ Text Message ☐ Phone Call/Voicemail ☐ Email

Name: _____ Relationship to patient: _____ Signature: _____ Date: _____/_____/_____

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Financial Policy

PAYENT METHOD: Payments are due at the day of the appointment. We will present the estimated insurance coverage, and if there is a copayment, it must be collected at the day of the appointment. If by any chance the insurance pays less than the estimated insurance coverage we presented, the outstanding balance becomes your responsibility. We accept all major credit cards, checks, cash, and FSA/HSA medical cards. A $25 fee will be charged for any declined payments (e.g., returned checks, expired credit cards). A finance charge will accrue on the outstanding balance if left delinquent for over 60 days at the rate of 2% per month. Should you need any further assistance, like setting up a payment plan, please inform our front desk coordinators to have you sign an additional form.

INSURANCE: We accept most dental insurance plans, **except** Medicaid (Medi-Cal), Medicare, DeltaCare, and all HMO plans. **HMO plans** only work at assigned/selected practices from a list of contracted providers. **We are not contracted with any PPO plans; therefore, we are Out-of-Network.** Out-of-Network simply means the allowable fees may not be the same as our fees, which may require a copayment from you. **Insurance coverage are all estimates and not guaranteed.** Make sure you are fully aware of your insurance policy prior to scheduling an appointment. As a dental provider, our role is to solely provide dental services and collect payments. Any issues addressed by your dental insurance are 100% your responsibility. *We bill insurances as a courtesy we extend to our patients.*

APPOINTMENT POLICY: We require a 48-hour or two-day notice to cancel or reschedule any appointments. Failure to do so will result to a $50 or $100 fee depending on the procedures for the appointment. For IV cases, we will keep deposits when you cancel or reschedule less than 48 hours or two days of the appointment, or when the patient breaks the prohibitions of the anesthesiologist.

_____

Signature of Patient or Parent/Legal Guardian

_____

Name of Patient or Parent/Legal Guardian

_____

Today's Date

HIPAA Security and Privacy Regulations
Authorization Form

Acknowledgement of Notice of Privacy Practices for Protected Health Information (§164.520(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's **Notice of Privacy Practices** prior to signing this acknowledgement, and;
- this facility reserves the right to change their **Notice of Privacy Practices** and prior to implementation, will mail a copy of any revised notice to the address I have provided, if requested.

Acknowledgement of Uses and Disclosures to Carry Out Treatment, Payment, or Health Care Operations (§164.506(a))

I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided, and;
- a tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals.

Acknowledgement of Uses and Disclosures for which an Authorization is Required (§164.508(a))

I understand that as part of my care and treatment, it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me. I understand that:

- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon, and;
- it is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature of Patient or Parent/Legal Guardian: _____

Name of Patient or Parent/Legal Guardian: _____

Today's Date: _____