Welcome

8204 Huntington Dr, Suite B
San Gabriel, CA 91775
Phone: (626) 656-8680
Fax: (626) 656-8682

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate _____/_____/_____ Child's Age _____

School_____Grade_____

Child's Home # (_____)_____

SS#_____

Child's Home Address:_____

_____
City State Zip

Email Address:_____

2. Who may we thank for referring you to our office?

_____

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship_____

Do you have legal custody of this child? ☐ Yes ☐ No

6. Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

_____
City State Zip

Home # (_____)_____

Work # (_____)_____

Cellular # (_____)_____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain_____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding	Y N Handicaps/Disabilities
Y N Allergies to any Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorders
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + / AIDS
Y N Congenital Birth Defects	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Diabetes

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good **Fair** **Poor**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

FINANCIAL POLICY

We are dedicated to providing all our patients with the finest service and treatment available. In doing so, we are happy to provide complimentary insurance verification and claim submittal. We file all insurance electronically, so your insurance company will receive each claim within a few days of the treatment. You are responsible for any balance on your account after 30 days, whether insurance has paid or not. If you have not paid your balance within 60 days, a re-billing fee of 1.5% (18% annual rate) will be added to your account each month until paid. You are responsible for knowing your insurance benefit coverage as well as your claim history, frequency limitation stated by your insurance company.

Payment: Payment is due at the time when services are rendered. Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment with our practice. We accept the following forms of payment: Cash, Check, all major Credit Cards (Visa, MasterCard, and Discover). If the amount which will be paid by insurance is important in determining the choice of treatment, I will find out this information before starting treatment. (**Initial**) _____

Check-in: Please bring your current insurance cards with you to EACH VISIT. Without the insurance card, we will be unable to file your insurance, and you will be responsible for the payment that day. On Follow-up visits, you will be asked to verify demographic and insurance information so that our records remain up-to-date. Please notify us ASAP if your insurance carrier or policy changes, as this may affect your payment.

Check-out: Please be prepared to pay for current visits as well as any past due balances account. Payment of co-pays, deductible fees for non-covered services will be required at the time of service.

If we are a contracted provider with your plan, you are responsible only for your portion of the approved fee as determined by your plan. We are required to collect the patient's portion (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan) in full at time of service. If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this and you will be responsible for the difference.

If we are not a contracted provider with you dental benefit plan, it is the insured's responsibility to verify whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement for services from out-of-network providers, our practice can file the claim with your insurance provider as a courtesy to you.

Authorizations: I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services that my child may need and have consented to during diagnosis and treatment. (**Initial**) _____

I have read the above and agree to the financial terms. (**Initial**) _____

In requesting examination and/or treatment on or after this date, I authorize the release of all information (including x-rays) relating to such examination or treatment to any health service plan or insurance company from which benefits have been paid or may be payable. I hereby authorize payment directly to Toni Chen DDS, Inc. of the group insurance benefits otherwise payable to me. I understand that any overpayment (over $20) caused by my previous personal payment will be refunded to me. Any payment less than $20 will be kept on my balance unless I request for a refund. (**Initial**) _____

I hereby acknowledge that a copy of this practice's Dental Materials Fact Sheet has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet. (**Initial**) _____

Guardian's Name (Print): _____

Guardian's Signature: _____ **Date:** _____

OUR APPOINTMENT POLICY

We reserve time on the schedule for each patient procedure and are diligent about being on-time. Please note that we do not double or triple book our patients for treatment appointments. Because of this courtesy, when a patient cancels and appointment, it impacts the overall quality of service we are able to provide.

If you are going to be **more than 15 minutes later** for your appointment, please call our office so we can determine if your appointment needs to be rescheduled so that other patients are not inconvenienced. We will always make it our priority to see your child/children on the same day when possible. We understand that your time is valuable, so we make every effort to seat each patient punctually; we ask for the same respect and courtesy in return. (**Initial**) _____

To maintain the utmost service and care, we do require **48-hour notice** to reschedule an appointment. This is a courtesy not only to us, but to other patients, who may be waiting for an opening in the schedule. This gives us ample time and opportunity to offer that appointment slot to another patient. (**Initial**)_____

When you **miss, reschedule, or cancel** your appointment without giving our office at **least 48 hours notice**, we reserve the right to assess a **fee** of **$25 for exam visits** and **$100 for treatment** appointments**.** (**Initial**) _____

Patient Name: _____ **DOB:** _____

Guardian's Name (Print): _____

Guardian's Signature: _____ **Date:** _____

INFORMED CONSENT FOR DENTAL TREATMENT

I acknowledge that the treatments listed have been explained to me and that I understand either through my own knowledge or from explanation by the doctor and staff what the advantages/benefits and disadvantages/risks of treatment and non-treatment are. I am satisfied that any reasonable treatment alternatives have been presented for my consideration. I have had the opportunity to ask questions and receive answers regarding the proposed treatment. Therefore, I give my consent for these treatments and for the administration of any local anesthesia necessary to provide them.

Anesthetizing agents are infiltrated into a small area or injected as a nerve block directly into a larger area of the mouth with the intent of numbing the area to receive dental treatment.

Risks include but are not limited to: It is normal for the numbness to take time to wear off after treatment, usually two or three hours. However, it can take longer and rarely the numbness is permanent if the nerve is injured. Infection, swelling, allergic reactions, discoloration, headache, tenderness at the needle site, nausea, vomiting, and cheek, tongue, or lip biting can occur.

Potential benefits: The patient remains awake and can respond to directions and questions. Pain is lessened or eliminated during the dental treatment.

PATIENT ACKNOWLEDGEMENT OF RECEIPT

OF DENTAL MATERIALS FACT SHEET

I acknowledge receipt of a copy of the Dental Materials Fact Sheet from Toni Chen D.D.S, Inc Dental Office. A list of dental material comparisons and definitions are available for review at the office and a copy can be reproduced for me to take home at my request.

Patient Name: _____ **DOB:** _____

Guardian's Name (Print): _____

Guardian's Signature: _____ **Date:** _____