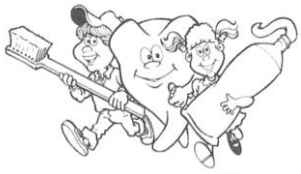
SIMON P. MORRIS, D.D.S.



MAI DINH D.D.S., M.S.

CHILD'S REGISTRATION & HISTORY

Child's name _____ Nickname _____
FIRST MIDDLE LAST

Date of birth _____ Age _____ ☐ Male ☐ Female

Child's interests _____ Pets _____

Other children in family who are or were patients here (name & ages) _____

Whom may we thank for referring you? _____

Parent Name _____

Relationship to child _____

Parent Birthday _____

Home address _____

City _____ Zip code _____

Home phone _____

Cell phone _____

Email _____

Occupation _____

Driver's License # _____

Parent Name _____

Relationship to child _____

Parent Birthday _____

Home address _____

City _____ Zip code _____

Home phone _____

Cell phone _____

Email _____

Occupation _____

Driver's License # _____

Child lives with: Both parents ☐ Mother ☐ Father ☐ Other ☐

In case of emergency who should be notified (other than parents) _____ Phone # _____

Party responsible for this account _____

Dental Insurance (note: to bill dental insurance we either need insurance ID # or employee's social security #)

Prime Carrier _____ Group # _____

Employee Name _____ Employed by _____

Insurance ID # _____ *or* Employee Social Security # _____

Secondary Carrier _____ Group # _____

Employee Name _____ Employed by _____

Insurance ID # _____ *or* Employee Social Security # _____

I authorize this office to affix my name to insurance claims and to release information to insurance companies.

Signed: _____ Date: _____

CHILD'S NAME _____

MEDICAL INFORMATION

Child's physician _____ Phone _____ Date of most recent visit _____

Is you child taking any medications (including over the counter) **yes / no**

If yes, please list: _____

Has your child ever been hospitalized? **yes / no**

If yes, please explain_____

Is your child allergic to any medications? **yes / no**

If yes, please list medication and nature of allergic reaction: _____

Is your child allergic to latex? **yes / no** Does your child have any other allergies? **yes / no** if yes**,** please list: _____

Has your child been diagnosed with any of the following? (please circle yes or no for each)

anemia	**yes / no**	cerebral palsy	**yes / no**	hearing problems	**yes / no**	kidney disease	**yes / no**	Rheumatic fever	**yes / no**
asthma	**yes / no**	developmental delay	**yes / no**	heart disease	**yes / no**	liver disease / hepatitis	**yes / no**	seizures / epilepsy	**yes / no**
autism	**yes / no**	diabetes	**yes / no**	heart murmur	**yes / no**	mental retardation	**yes / no**	thyroid disorder	**yes / no**
birth defects	**yes / no**	Down syndrome	**yes / no**	HIV positive	**yes / no**	more than 4 wks premature	**yes / no**	tuberculosis	**yes / no**
blood disease or bleeding problems	**yes / no**	fainting	**yes / no**	joint / bone problems or surgeries	**yes / no**	physical disability	**yes / no**	tumors / cancer	**yes / no**

Are there any other medical conditions concerning your child that are not listed above? **yes / no** _____

BEHAVIORAL INFORMATION

Does your child have any behavioral or emotional problems? **yes / no** _____

Does your child have any learning disabilities? **yes / no** _____

Does your child have any sensory concerns? **yes / no** _____

Has your child ever had any experiences that may cause apprehension in the dental office? **yes / no** _____

DENTAL INFORMATION

Do you have any concerns today about your child's teeth? ? **yes / no** _____

Has your child been to the dentist before? **yes / no** How long ago? _____ Were radiographs (x-rays) taken? **yes / no**

How often does your child brush? ___ **times per day** How often does your child floss? ___ **times per week**

Does your child receive help brushing and flossing? **yes / no** Does your child use a toothpaste with fluoride? **yes / no**

Does your child use a nursing bottle or sippy cup**? yes / no**

Does your child regularly eat or drink (other than water) after brushing at night? **yes / no**

Does your child have any of the following (**please circle**) thumb sucking, pacifier use, speech problems, snoring, tooth grinding?

Do you or your spouse have a high cavity rate or any serious dental or gum problems? **yes / no**

Are there any other facts about your child that you feel we should know or you would like us to consider? **yes / no**

_____

_____

I certify that the above information is accurate to the best of my knowledge. I will inform Dr. Morris, Dr. Dinh or one of the associate dentists if any changes occur to my child's health.

Signed:_____ Date: _____

. Parent or Guardian

Consent for Dr. Morris, Dr. Dinh and Dr. Lotwala to Provide Pediatric Dentistry

- I give my permission for Dr. Morris, Dr. Dinh and Dr. Lotwala to use such measures as deemed necessary by their professional judgment to provide comprehensive pediatric dentistry for my child.

- Please note that specific treatment will be discussed in advance.

- Any use of sedation will be discussed in advance and will involve a separate verbal or written consent.

- Although very rare, I understand that during and after the course of dental treatment complications may arise.

- I understand that the practice of dentistry is not an exact science and that there is no guarantee that dental treatment will be successful.

- I understand that during dental treatment, the nature of the treatment may change due to the condition of the tooth at that moment. Every effort will be made to inform you of any changes.

_____ _____ _____

Child's Name *Parent / Guardian's Name* *Relationship to Child*

X _____ Date _____

Signature of Parent / Guardian

Financial Policy
Simon P. Morris D.D.S. Inc. and associates

Thank you for choosing us as your child's dental care provider. We are committed to your child's treatment being successful. Please understand that payment of your bill makes it possible for us to remain a viable dental practice. The following is a statement of our Financial Policy, which we ask you to read and sign prior to any dental treatment. Please let us know if you have any questions or concerns. We are happy to provide any answers and are committed to making your child's and your visit as pleasant and educational as possible.

Our policy is as follows

- The parent or legal guardian of the minor patient is responsible for full payment.
- We accept cash, checks, or VISA / MasterCard
- We will submit to insurance but if your insurance has not paid within 45 days, the balance becomes due.
- Payment plans are available at the discretion of our Financial Coordinator.

Regarding Insurance and "In Network"

For accounts in good standing, we will be happy to accept assignment of benefits if you provide all the necessary information. Any insurance that needs to be rebilled because of incorrect information will be subject to a resubmission fee of $5.00. The estimated uninsured portion of your dental treatment fee is due at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance has not paid in full within 45 days, the balance becomes due. A $5.00 late fee will be charged on accounts that are past due. If your account becomes in bad standing, we may not bill the insurance company. Instead we will ask for payment in full at the time of service and provide you with insurance forms for you to bill your own insurance.

If you have the type of dental insurance where you have to go to a dentist on a list, the only insurance we are contracted with (in network) at this time is Delta Dental Premier (Dr. Morris and Dinh) and Delta PPO (Dr. Dinh only.) We can bill all insurances but some of them provide better coverage if you go to a dentist who is contracted with (or "in network") with that company.

Overdue Accounts

If your account becomes overdue and you are not working with us to take care of it, then your child will be dismissed as an active patient and your account may be submitted to a licensed collection agency.

Usual & Customary Rates

Our practice is committed to providing the best treatment for your child and our fees are what we consider usual and customary for the specialty services we provide in this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments and Late Cancellations

Because time is reserved for your child, a fee of $50 will be assessed for a missed appointment or one not cancelled at least 24 hours in advance (48 hours if cancelling a Monday appointment). Please help us serve your child better by keeping scheduled appointments.

I have read and understand the Financial Policy. I understand and agree to this Financial Policy. I authorize payment to be made directly to the dentist by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any dental care information requested by my insurance company.

_____ _____ _____

Child's Name *Parent / Guardian's Name* *Relationship to Child*

X _____ _____

Signature of Responsible Party *Date*

Acknowledgement of Receipt of Privacy Policy Practices

Simon P. Morris D.D.S. Inc. and associates

** You may refuse to sign this acknowledgement**

As required by California law, I have received a copy or access to a copy of this office's Notice of Privacy Practices. (policy may be found in our office or on our website).

_____ [Parent Name]

_____ [Signature]

_____ [Date]

Office Notes:

Acknowledgement of Receipt of Dental Materials Fact Sheet

As required by California law, I have received a copy or access to a copy of Dental Materials Fact Sheet (fact sheet may be found in our office or on our website).

_____ [Parent Name]

_____ [Signature]

_____ [Date]