LITTLE ROOTS
PEDIATRIC DENTISTRY

New Patient Registration

Patient Name: _____ DOB: _____

Gender (circle one): Male Female

School Name: _____ Grade: _____

Allergies: _____

Pediatrician's Name: _____

Phone Number: _____ City: _____

Parent 1 Name: _____ DOB: _____

Address: _____ Zip code: _____

Phone Number: _____ Occupation: _____

Email Address: _____

Parent 2 Name: _____ DOB: _____

Address: _____ Zip code: _____

Phone Number: _____ Occupation: _____

Email Address: _____

Primary Contact: (Circle One) Parent 1 Parent 2

How did you hear about us? _____

Insurance Information

PRIMARY?

Insured/Subscriber Name: _____ DOB: _____

Insurance Name: _____

Member ID# or SSN: _____ Group#: _____

SECONDARY?

Insured/Subscriber Name: _____ DOB: _____

Insurance Name: _____

Member ID# or SSN: _____ Group#: _____

FINANCIAL POLICY

1.Patients WITH Insurance Coverage:
Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for the payments of your account. We can request a pre-estimate of benefits from your insurance carrier if you request to do so. However, pre-estimate of benefits is not a guarantee of payment by your insurance carrier. Routine treatments are generally performed without submitting a request of pre-estimate of benefits.
Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due prior to the treatment. If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you. In some cases, your insurance carrier may pay for alternative benefits other than the treatment performed. In this case, you are responsible to pay for the difference. Even if you have dual coverage (which is possible when you and your spouse both have insurance) there may still be a portion that is your responsibility.
All procedures involving lab work will require 50% down payment, then the remaining 50% balance will be due as treatment progresses. The balance must be paid before final insertion.
If you are having extensive treatment over a period of time, we request payments during the course of treatment. Our office manager will assist you in arranging a payment schedule.

2. Patients WITHOUT Insurance Coverage:
Patients without insurance coverage are required to pay for services as rendered. We accept Cash, MasterCard, Visa, Discover, or American Express cards. We also arrange pre-payments and third-party financing plans with Care Credit.
By signing below, you have read, and understand this agreement.

_____ _____

Parent/ Guardian Signature Date

Cancellation Policy

When you reserve a time with us please make every attempt to make your appointment. We do not "double book" as many offices do. This time is set aside specifically for you. One week prior to your appointment you will receive an email, text message or a phone call if you do not wish to receive text messages. When you receive this message, please call, text or email us to **confirm** the time that you have already reserved with us. If we have not heard back from you **24 BUSINESS HOURS** (For appointments on Monday you must call on Saturday as we are closed on Sundays) prior to your reserved time, we will take your appointment off of our schedule. We have a 24 BUSINESS HOURS cancellation policy. If you need to change or reschedule your reserved time with us, please give us at least a 24 BUSINESS HOURS (72 hours for an appointment with the specialist) notice so that we will be able to fill this time with others waiting for treatment. If your appointment time with us is on Monday at 8:00 am, please confirm with us by Saturday at 8:00 am, etc. If you cancel, fail to show for your confirmed appointment, or you arrive excessively late and treatment cannot be completed as planned, we recover our lost opportunity and associated costs for having our Staff on standby with a Broken Appointment Fee of $50 per hour scheduled. This may sound harsh, but please understand that if you have TWO broken appointments, we reserve the right to release you as a patient and ask that you seek treatment at another Dental Practice. Thank you for understanding this policy. LATE ARRIVAL If you are over 15 minutes late for your appointment, we reserve the right to reschedule your appointment for a later time. The Broken Appointment Fee of $50 will apply to this as well. Please understand that we strive to stay on time for your appointment as well as those patients that follow you. The broken appointment Fee will not be incurred in the case of emergencies.
By signing below, you have read, and understand this agreement.

_____ _____

Parent/ Guardian Signature Date

HIPAA Release Form

Patient Name: _____ DOB: _____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information:
This information may be release to
[ ] My spouse (full name): _____ DOB: _____
[ ] My children [ ] Other

[ ] Don't release this information to anyone

If "other", please inform their name and contact number

_____

This Release of Information will remain in effect until terminated to me in writing.

Messages
It is okay to leave a message:
[ ] Home phone [ ] Work phone [ ] Mobile phone

If unable to reach me:
[ ] You may leave a details message
[ ] Leave a message asking me to return your call
[ ] Do not leave a message

_____ _____

Parent/ Guardian Signature Date

LITTLE ROOTS
PEDIATRIC DENTISTRY

Medical Health History

Patient Name: _____ DOB: _____

Has your child had any of the following problems: *Please circle yes or no (do not leave blank)*

Anemia	YES	NO	Hemophilia	YES	NO
Asthma	YES	NO	Hepatitis	YES	NO
Autism Mild-Moderate	YES	NO	High blood pressure	YES	NO
Autism Moderate-Severe	YES	NO	High fevers	YES	NO
ADD/ADHD	YES	NO	HIV+ / AIDS	YES	NO
Behavior problems	YES	NO	Kidney disease	YES	NO
Birth defect	YES	NO	Learning disability	YES	NO
Cancer or tumors	YES	NO	Liver disease	YES	NO
Cerebral Palsy	YES	NO	Nutritional problem	YES	NO
Convulsions	YES	NO	Psychiatric Care	YES	NO
Diabetes	YES	NO	Rheumatic / Scarlet fever	YES	NO
Ear infection	YES	NO	Sickle Cell Anemia	YES	NO
Epilepsy	YES	NO	Speech problems	YES	NO
Prolonged bleeding	YES	NO	Tonsillitis	YES	NO
Fainting / dizziness	YES	NO	Tuberculosis	YES	NO
Handicaps / disabilities	YES	NO	Vision problems	YES	NO
Hearing problems	YES	NO	Latex Allergy	YES	NO
Heart trouble	YES	NO	Any special problems not listed above? _____		
*Heart Murmur	YES	NO	_____		

(*If yes, please provide a cardiologist release form)

MTHFR Gene Mutation: Has your child been diagnosed w/MTHFR Gene Mutation or is there a chance your child may have this mutation? *(Circle one)* YES NO

Does your child have any allergies or reactions to any medications? *(Circle one)* *YES* *NO*

If yes, please indicate: _____

Please list all medications that your child is currently taking: _____

_____

Is your child currently under the care of a physician? (specialist?) *(Circle one)* *YES* *NO*

Describe: _____

Are immunizations up to date? *(Circle one)* *YES* *NO*

Were there any problems during pregnancy, delivery, or during the first year of your child's life? *(Circle one)* *YES* *NO*

Describe: _____

Dental History: Has your child had any of the following problems? *Please circle yes or no (do not leave blank)*

Lip sucking / biting habits	YES	NO	Any problems w/ previous dental work	YES	NO
Nail biting habits	YES	NO	Describe _____		
Thumb / finger sucking habits	YES	NO	Hospitalization	YES	NO
Nursing bottle habits	YES	NO	Injuries to face, mouth, or teeth	YES	NO
Pain / tenderness in the jaw	YES	NO	Describe _____		

PREVIOUS DENTIST INFORMATION: Name: _____ Phone: _____

Date of last dental visit and x-rays? _____

Please read carefully initial, sign and date the following statements. Thank you.

1. I understand the above information is necessary to provide my child with the dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. Initial _____
2. I understand that it is my responsibility to advise the office of any changes in the information contained on this form. Initial _____

Parent or Guardian Signature: _____ Date: _____

Doctor Signature: _____

Photo/Video Release Form

Little Roots Pediatric Dentistry
1202 Bristol St #140
Costa Mesa, CA 92626
714-477-2906

As part of client care and company giveaways, I understand that Little Roots Pediatric Dentistry may record, photograph, and/or videotape me (collectively the "Recordings"). Such Recordings may consist of videotaping or photographing giveaways, drawings, company events, publicity, illustration, advertising, Web content, treatment, and treatment results. Such Recordings or Photographs may include materials protected by various state and federal privacy laws, and may be protected by copyright laws and laws concerning the right to publicity.

I hereby authorize Little Roots Pediatric Dentistry to create the Recordings/Photography. I further provide and grant Little Roots Pediatric Dentistry full permission/rights to use, publish, reproduce and/or exhibit the Recordings for any legal purpose including, but not limited to, educational, training, or promotional purposes related to Little Roots Pediatric Dentistry. This permission includes, without limitation, the right to use, publish, reproduce and exhibit the Recordings in Little Roots Pediatric Dentistry various printed promotional displays, electronic/ online media and training tools, and during live training provided by Little Roots Pediatric Dentistry

I understand that all photos and/or videos recordings taken are without compensation to me, the undersigned, and are the property of Little Roots Pediatric Dentistry. I hereby waive any and all claims to said Recordings/Photographs, including but not limited to any rights to fees, royalties or other compensation which may arise from my participation in the Recordings/Photographs. I understand that Little Roots Pediatric Dentistry shall not be liable for the release of any Recordings/Photographs. I forever release and Little Roots Pediatric Dentistry, its employees, officers, licensees, agents and governing board from any claims, actions, damages, liabilities, costs or demands whatsoever arising by any reason of defamation, invasion of privacy, right to publicity, copyright infringement, or any other personal or property right from or related to any use of the Recordings/Photographs.

I hereby acknowledge that I have read and understand the terms of this release form. ***(Circle one)***

CONSENT **DECLINE**

_____ _____
Patient Name Date

_____ _____
Parent/Guardian Signature Parent/Guardian Printed Name