CHILDREN'S HEALTH HISTORY

Date_____
Patient's Name_____Nickname_____Sex_____
Age_____Birthday_____Weight_____ Home#_____
Change in address? Y/N New Address:_____
Email: _____Cell Phone# _____
Please give a reason for this visit_____

MEDICAL HISTORY

1. Has your child had any history of heart trouble/heart murmur? ___Y___N
2. Has your child had rheumatic fever? ___Y___N
3. Does your child have cancer? ___Y___N
4. Does your child have epilepsy or seizures? ___Y___N
5. Does your child have any personal handicaps? If so, what? ___Y___N

   _____
6. Is your child allergic to any medication or food? If so, what? ___Y___N

   _____
7. **Does your child have a LATEX allergy?** **___Y___N**
8. Does your child have prolonged bleeding from cuts? ___Y___N
9. Has your child had a history of diabetes, kidney problems, blood disorders, or asthma? (If Yes Circle Condition) ___Y___N
10. Is your child in generally good health?
    ___Y___N
11. Please describe any other medical problems. (mental or physical)

    _____
12. Pediatrician (physician)_____
13. Date of last medical examination_____

DENTAL HISTORY

1. Is this your child's first visit to the dentist? ___Y___N
2. Has your child experienced any unfavorable reaction from any previous dental or medical care? State what._____ ___Y___N

   _____
3. Does your child have any mouth habits (thumb sucking, pacifier, etc.) ___Y___N
4. Do you desire complete dental care for your child? ___Y___N
5. Last examination:_____
6. Last dental x-rays:_____
7. Last topical fluoride:_____
8. Your family dentist:_____
9. What particular dental problems does your child have?_____

   _____
10. List current medications:_____

_____ _____ _____
Signature of Parent/Guardian Date Reviewed By

CHILD'S REGISTRATION

PARENTS FULL NAME:
Father_____DOB_____
Mother_____DOB_____
Home Address_____
City_____State____Zip_____
Home Telephone_____Cell Phone_____
Name and address of nearest relative (not living with you)_____
_____Telephone_____

PLACE OF EMPLOYMENT
Father_____Phone_____
Company Address_____
Mother_____Phone_____
Company Address_____

Who is responsible for this account?_____
Their Social Security number_____
Date of birth _____
Their Driver's License Number_____
Name of Dental Insurance Company_____
Group Policy Number_____

CONSENT

The undersigned, with prior approval, hereby authorizes Dr. Kapur and Associates to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with Dental Treatment for_____

Signature_____Date_____
Relationship_____

FEES FOR SERVICES RENDERED ARE PAYABLE UPON CONCLUSION OF EACH APPOINTMENT!!!

ASSIGNMENT AND RELEASE

I, undersigned, have insurance coverage with _____ and assign directly to Shashi M. Kapur D.D.S.,M.Sc.D.,PC, all dental benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the Doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions. Additional charges will be added for returned checks and accounts sent for collection.

_____ _____
Signature of Parent/Guardian Date

Arizona Pediatric Dentistry
Practice Limited to Pediatric Dentistry
600 S. Dobson Rd., Bldg. C, Ste. 18
Chandler, AZ 85224

WELCOME TO OUR PRACTICE

As a service to our patients, we are happy to submit your dental claims to your insurance carrier. Many dentists do not offer this service, and the patients must pay in full at the time of service and take care of their own insurance paperwork.

We try as best we can to **ESTIMATE** what your insurance company will pay us on each claim we submit, and then collect what we believe is your portion at the time of service.

We deal with literally hundreds of insurance companies that represent hundreds of employers, each with their own separate policies. It is impossible to know all limitations of each and every policy our many patients have. In addition, many insurance companies will not release information to the doctor's office concerning their policies and benefits, and *no insurance company guarantees payment of any claim!!*

Therefore should there be a discrepancy between what we have estimated your portion to be and what the insurance company pays us, this amount *becomes your responsibility* to remit to the doctor.

Thank you for your understanding in this matter.

I the undersigned have read and understood the above statement.

Signature_____ Date_____

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APPOINTMENT POLICY

We schedule our dental appointments very carefully to assure all of our patients are seen promptly, and sufficient time is allowed for each procedure. We do this because we value and respect our patient's time and desire to provide the best treatment possible. In order to remain on schedule, we request that you arrive on time for your appointments.

Occasionally, emergencies arise which may cause us to run over into your appointment. Every effort will be made to inform you of this, if this situation arises. We appreciate your understanding, as someday you or a family member may be in need of emergency dental care.

48 HOUR NOTIFICATION IS REQUIRED TO AVOID A CANCELLATION CHARGE. THE MINIMUM FEE IS $100.00 PER HOUR FOR PROCEDURE TIME SCHEDULED. When we are not notified a missed appointment means another patient, who could have been seen, was not

I have read and understood the above.

Signature_____Date_____

Financial Policy

We are committed to providing you with the best possible care. If you have dental insurance, we will assist you be billing your claim for benefits. We need your assistance, and your understanding of our financial policy.

Payment for services is due at the time of services are rendered, unless our staff has approved payment arrangements in advance.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. However, please keep in mind that:

1. You, the patient/insured, are ultimately responsible for your bill

2. Your insurance is a contract between you, your employer, and the insurance company.

3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover. I.E. sedation, analgesia.

We must emphasize that as a dental provider, our relationship is with you, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all our charges are your responsibilities from the date of services are rendered. We realize that temporary financial problems may affect timely payments of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

A $25.00 charge will be applied to your account for checks that are returned for insufficient funds. A $75.00 charge will be added to account balances over 60 days when transferred to an outside agency for collection.

If a referral is required and you fail to bring one, you will be responsible for the bill.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help.

I have read the above financial policy for Shashi M. Kapur D.D.S. and understand that I am responsible for all accrued charges including those charges, which my insurance company may or may not cover at the level, anticipated. Additionally, I understand that should my insurance company delay payment past 30 days, I will be billed and be responsible for the entire balance.

Signature_____Date_____

Arizona Pediatric Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Parent Giving Consent.

Name:_____

Address:_____

Telephone:(____)_____-_____ E-mail_____

Patient #: _____ Social Security # :_____

Section B. To the patient – Please read the following statements carefully

Purposed of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to chance our privacy practices as described in our Notice of Privacy Practices. If we change our Privacy Practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time be contacting :

Contact Person: Usha

Telephone: (480)820-6778 Fax (480)820-3606

Address: 600 S. Dobson Rd C-18; Chandler, AZ 85224

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry our treatment payment activities and health care operations.

Signature_____ Date_____

If this Consent is signed by a person representative on behalf of the patient, complete the following:

Personal Representative's Name_____

Relationship to Patient:_____

You are entitled to a copy of this Consent after you sign it.