Tell us about your child

Fountain Plaza Family Dental
Wallace J. Bellamy, DMD

Child's Name: _____ Nickname: _____
Last *First* *MI*

Child's Birthdate: _____ Social Security #: _____ Child's Age: _____ Gender: _____

School: _____ Grade: _____

Child's Home Address: _____
Street *City* *State* *Zip*

What is the primary reason for today's visit? _____

How did you hear about us? *(Check the boxes that apply)*

□ **Drive-by/Walk-In** □ **Yelp** □ **Review Website** □ **Facebook** □ **Google** □**Other**

□ **Referred by patient? If so, please list their name: _____**

□ **Referred by Pediatrician or Dentist? If so, please list their name: _____**

Dental History

Is this your child's first dental visit? □ **Yes** □ **No**

Is your child currently in pain? □ **Yes** □ **No**

If so, please explain: _____

Has your child experienced problems with previous dental treatment? □ **Yes** □ **No**

If yes, please explain: _____

Previous Dentist: _____ Date of last visit: _____ Date of last x-ray: _____

Why did you leave your previous dentist? _____

Have there been any injuries to your child's teeth or jaws? □ **Yes** □ **No**
Does your child take fluoride, vitamins, or drink fluoridated water? □ **Yes** □ **No**
Does your child floss? □ **Yes** □ **No**
Generally, how often does your child brush their teeth? □ **Yes** □ **No**
Has your child been seen by an orthodontist? □ **Yes** □ **No** Who? _____

Does/Did your child have any of the following habits: *(Check the boxes that apply)*

□ **Breast Fed**	□ **Lip sucking/Nail Biting**	□ **Sippy Cup**
□ **Chewing on objects**	□ **Mouth Breather**	□ **Thumb/Finger sucking**
□ **Clenching/Grinding teeth**	□ **Nursing bottle habits**	□ **Tongue/Cheek biting**
□ **Jaw Pain**	□ **Pacifier**	□ **Tongue thrust**

Medical History

Child's Physician: _____ Phone: _____ Date of last visit: _____

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

If yes, please explain: _____

Does your child have social/personality/temperament concerns that we should be aware of? _____

_____

Please describe your child's physical health: □ **Good** □ **Fair** □ **Poor**

Are immunizations current? □ **Yes** □ **No**

Please list all medications and dosage that your child is currently taking:

Please list all drugs and /or things that cause your child allergic reactions:

Anything you would like to discuss with the doctor in private? □ **Yes** □ **No**

Has your child had/experienced any of the following: *(check the boxes that apply)*

□ **Abnormal bleeding**	□ **Cancer/Tumors**	□ **Hearing Problems**	□ **Sight disorders**
□ **ADD/ADHD**	□ **Celiac disease**	□ **Hepatitis**	□ **Social delays**
□ **AIDS/HIV+**	□ **Cerebral Palsy**	□ **High blood pressure**	□ **Speech delay**
□ **Anemia**	□ **Congenital birth defect**	□ **Kidney disease**	□ **Stomach/GI disease**
□ **Any hospital stays**	□ **Diabetes**	□ **Liver disease**	□ **Tuberculosis (TB)**
□ **Any operations**	□ **Endocrine system disorders**	□ **Low blood pressure**	□ **COPD**
□ **Asthma**	□ **Epilepsy/Seizures**	□ **Lupus**	□ **Snoring**
□ **Autism**	□ **Frequent headaches**	□ **Mental delays**	□ **Sleep-apnea**
□ **Blood disorder**	□ **Frequent infections**	□ **Physical delays**	□ **Acid reflux**
□ **Breathing/Lung problems**	□ **Heart condition/Murmur**	□ **Rheumatic fever**	

Please discuss any serious medical problems your child experiences, now or in the past:

Supplemental questions for Ages 12+:
Has your child experienced puberty? □ **Yes** □ **No**
Is your child pregnant or nursing? □ **Yes** □ **No** Is your child on birth control? □ **Yes** □ **No**

Insurance Information

Is your child covered by a dental insurance plan? □ **Yes** □ **No**

Primary Insurance
Insurance Co. Name: _____ Phone #: _____ Group #: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: _____Subscriber's ID #: _____ Employer: _____

Secondary Insurance
Insurance Co. Name: _____ Phone #: _____ Group #: _____

Subscriber's Name: _____ Relationship to Patient: _____

Subscriber's Birthdate: _____Subscriber's ID #: _____ Employer: _____

Legal Guardian's Information

Legal guardian #1 Email: _____

Name: _____ Birthdate: _____ Relationship to child: _____

Cell Phone: _____ Alt Phone: _____ Social Security #: _____

Legal guardian #2 Email: _____

Name: _____ Birthdate: _____ Relationship to child: _____

Cell Phone: _____ Alt Phone: _____ Social Security #: _____

Emergency Contact: _____ Address: _____ Phone: _____

Consent/Authorization for Dental Treatment of a Minor *California Family Code §6910*

All minors seeking dental treatment must be accompanied by a parent/legal guardian during the initial visit. After the initial appointment, a minor may be seen for treatment only with written authorization from the parent/guardian.

If you need to send your child to their appointment with an adult other than yourself/legal guardian, please complete this section:

I hereby authorize the following adult:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____,

to consent to dental treatment which is deemed necessary by Nikki Chauhan, DDS as authorized herein. A parent/legal guardian may appoint another adult to accompany the minor patient to the appointment. If the parent/legal guardian is not available, the California Family Code allows only certain adults to consent for medical treatment to minors if parent consent cannot be obtained. These are: a grandparent, an adult brother, sister, aunt or uncle, and any adult who has actual care, control, and possession of the minor and has written authorization to consent from the parent/legal guardian.

I understand this consent will be valid until I rescind this agreement in writing. I also understand I am responsible for all charges or fees incurred.

_____	_____	_____
Parent/Guardian Signature	***Parent/Guardian Printed Name***	***Date***

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and / or their health practitioners.

I have received a copy of this office's *Notice of Privacy Practices*. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature _____ Date _____

Consent for Dental Treatment

I request and authorize Dr. Bellamy and his staff to provide my child with a comprehensive examination and prescribe X-rays that may be considered necessary to diagnose and/or treat my child's dental condition. Thereafter, I will be presented the treatment recommendations, risks, benefits and options to make informed decisions about my child's care. At that time, I request and authorize Dr. Bellamy and his staff to complete the accepted treatment for my child.

Signature _____ Date _____

For Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian. **Initials _____ Date _____**

Child's Name: _____

HIV/AIDS/HEPATITS TESTING

As a patient of *Wallace J. Bellamy, DMD*, I **AGREE/DO NOT AGREE (*circle one*)** to be tested for *HIV/AIDS/HEPATITS Viruses* in the event that anyone on staff at Fountain Plaza Family Dental is punctured by a needle or other sharp instrument while performing dental procedures on me. Furthermore, in order to protect the confidentiality of all parties involved, I agree to share results of such testing only with the affected employee's medical practitioner.

Parent/Guardian Signature _____ **Date** _____

INFORMATION DISCLOSURE AND ADDENDUM NOTICE

There have been changes recently to laws governing disclosure and storage of patients' health records and other personal information. The purpose of this notice is to inform you of your rights as a patient, as well as the steps we take to ensure your privacy and to whom we disclose your private information.

First, please know that we take your privacy very seriously. We do not disclose your private information for marketing purposes of any kind! In the past, we have provided information to specialists when we referred our patients to them for treatment, such as dates of birth, social security numbers, and insurance information. Under the new legal constraints, we would have to obtain your written permission each time that we provide such information. The only time that we release your personal billing information is when we submit claims to your insurance carrier. Most insurance companies identify patients by their social security number and date of birth. Revealing your confidential treatment information is essential to getting the claim paid. If you would prefer not to give us your social security number, you are welcome to pay for your visit at the time of service by cash, or money order and we will provide you with the computer-generated form to bill your insurance company for reimbursement.

I authorize release of personal information to my insurance company(s) and assignment of benefits to Wallace J. Bellamy, DMD.

Parent/Guardian Signature _____ **Date** _____

If I decide to go to another healthcare provider, and that provider requests a copy of my x-rays/dental records be sent to them, I authorize release of those records.

Parent/Guardian Signature _____ **Date** _____

INFORMATION DISCLOSURE AND ADDENDUM NOTICE

As a patient, you have the right to review your child's records during our business hours with reasonable notice. Pursuant to California Health and Safety Code Section 12311(SB 1903), an adult patient may provide a written addendum, up to 250 words per item, to his or her dental record if the patient believes that the records are incomplete or inaccurate. The addendum then becomes part of the patient's record and must be attached and included when the record is disclosed to other parties. If you feel that your privacy has been maintained, or that our privacy procedures are inadequate, you have the right to file a written grievance with *Wallace J. Bellamy, DMD*.

I understand that I have the right to review and amend my Childs dental records, and that I have the right to file a written grievance if my Childs privacy is not maintained.

Parent/Guardian Signature _____ **Date** _____

Consent to Dental Photography

I _____ ***(Patient Name)*** authorize *Wallace J. Bellamy, DMD* to take photographs and/or videos of my face, jaws, and teeth before, during, and after treatment.

I consent to allow the photographs to be used for the following:

- *Dental Records*
- *Dental Research*
- *Dental education, including lectures, seminars, demonstrations, professional publications such as journals or books*
- *Marketing material, including websites, printed materials, and patient education*

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.

I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your full-face shot used for any of the above purposes.

Parent/Guardian Signature _____ **Date** _____

Fountain Plaza Family Dental
Wallace J. Bellamy, DMD

Notice of Privacy Practices - HIPAA

This Notice describes how your health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your health information is important to us.

Our Legal Duty

Federal and state laws require us to maintain the privacy of your health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice took effect Nov 1st, 2018, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. For more information about our privacy practices or additional copies of this Notice, please contact us at (916) 683-3011.

Uses and Disclosures of Health Information

We use and disclose health information about you for treatment, payment, and healthcare operations.

For example:

Treatment: We disclose medical information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment: We may use and disclose your health information to obtain payment for services we provide you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it is in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions or disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, of if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payment for marketing activity you have authorized.

Change of Ownership: If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health: We may, and are sometimes legally obligated, to discuss your health information to public health agencies for purposes related to preventing or controlling disease, injury or disability; reporting abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. Upon reporting suspected elder or dependent adult abuse or domestic violence, we will promptly inform you or your personal representative unless we believe the notification would place you at risk of harm or would require informing a personal representative, we believe is responsible for the abuse or harm.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal official health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Appointment Reminders: We may contact you to provide you with appointment reminders via text, voicemail, email, postcards, or letters. We may also leave a message with the person answering the phone if you are not available.

Sign In Sheet and Announcement: Upon arriving at our office, we may use and disclose medical information about you by asking that you sign an intake sheet at our front desk. We may also announce your name when we are ready to see you.
and it must explain why the information should be amended. We may deny your request under certain circumstances.

APPOINTMENT GUIDELINES

Wallace J. Bellamy, DMD

We make every effort to value your time and we reserve your appointment time just for you. We consider all appointments confirmed once they are reserved.

We truly appreciate your courtesy of giving us ***48 hours' notice (2 business days, not including Friday - Sunday)*** if you have a conflict. We are committed to your oral health care and keeping your scheduled reservation allows us to be partners in your dental care.

We will waive your first missed reservation. However, a second missed reservation will require a deposit. The deposit will be applied towards your treatment. However, if you fail to keep that reservation, the deposit will be forfeited.

It is our philosophy to continue to put our patients first and to make your experience a positive one. Thank you for allowing us to share our Appointment Guidelines with you.

- I acknowledge an appointment is a reservation.
- I agree to provide a minimum of *48 hours' notice (2 business days, not including Friday - Sunday)* if I need to change my reservation.
- If I miss or change 2 reservations without the required *48 hours' notice (2 business days, not including Friday - Sunday),* I acknowledge that I will be charged $99/per reserved hour and will be required to pay a deposit at time of next scheduling.
- I acknowledge I am required to leave a deposit for any Nitrous Oxide procedures or Reservations over 2 hours in length.

_____ _____

Responsible Party or Patient (Print) Date

_____

Responsible Party or Patient (Signature)

OFFICE GUIDELINES

Wallace J. Bellamy, DMD

Our mission as individual dental professionals is to provide the highest quality of patient education and dental care to all patients that choose us for their dental care. Our hope is by providing you the following information we can prevent misunderstandings to ensure you encounter a positive experience. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT

To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience an estimate for services will be prepared in advance of your appointment/s to ensure you an opportunity to plan for your dental care. We believe whether you privately pay or have dental benefits to assist you, everyone deserves the care they need and want. It is necessary to provide accurate insurance information so estimates can be as accurate as possible. _____

Initials

DENTAL INSURANCE

We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request that you be familiar with your insurance benefits, and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within *45 days*. Please realize that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage or eligibility and your assistance may be requested to expedite the processing of your claim. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductibles, limitations, or maximums. _____

Initials

PAYMENT OPTIONS

For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service.

Cash/Check ☐ MasterCard ☐ Visa ☐ Other Extended Payment ☐ *(Please see below)*

If eligible we offer extended payment plans thru our third-party providers: Sunbit or CareCredit. Please Note: A $25.00 NSF fee will be charged for all returned checks.

_____

Initials

PAST DUE BALANCES

If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within *90 days*, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. Balances over 90 days may be subject to rebilling fee. _____

Initials

INFORMATION CHANGES

To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur. _____

Initials

Thank you for your understanding of the Office Guidelines!

My signature indicated that I understand the policies as outlined and any questions I have with regard to office policies have been answered.

_____ _____

Signature of Responsible Party or Patient Date

My signature indicates that I have reviewed the office policies with the responsible party and/or patient.

_____ _____

Signature of Staff Member or Doctor Date

Financial Policy

Thank you for choosing us as your Oral Health Care Provider. We look forward to providing you with quality service and the best experience possible! To make this happen, we rely on your representation that you will pay our office for the services we provide. In hiring our office to provide you with dental services, you agree to the following terms:

1. **Regarding Insurance.** We DO NOT dictate or limit our treatment prescription based on your insurance coverage. YOUR INSURANCE BENEFITS ARE DETERMINED BY YOUR EMPLOYER, NOT YOUR DENTIST. Please be aware that some, and perhaps all, of the services may be non-covered services under the terms of your insurance policy. As a courtesy, we will be glad to file your claim for you if you bring in your insurance card and all required employer information. You will be expected to pay up front for services rendered if the office is unable to verify your insurance information before any treatment.
2. **Payment is due.** Payment is due on the day of service. In some cases, when scheduling appointments for treatment, you may need to make a pre-payment of at least ½ that day (dental laboratories need payment at the time of first impression) and the remaining balance will be due the day services are rendered. We are pleased to offer these options for payment: cash, check, and all major credit cards. We also offer Care Credit and Sunbit, an excellent third-party payment plan for treatment over $100. You are invited to discuss your treatment with our business team to determine the most convenient method of payment for your individual situation. You will be responsible for a $35 fee if checks are returned to our office.
3. **Collections.** Statements will be sent out as insurance claims are received and then again once every month. Failure to pay balance 30 days after receiving final payment from insurance company may result in a finance charge to that account. Finance charges will keep accumulating every month until balance is paid off. After 90 days, patients who have failed to either communicate with our office and/or make a payment are subject to being sent to collections. By signing below, I agree to pay all amount(s) owed within 90 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my current/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it shall remain my responsibility to pay all amounts owing as set forth herein. In the event any amount(s) is/are referred to a third-party collections agency, I agree that in addition to any other amount(s) allowed by law (such as interest, court costs, reasonable attorney's fees, etc.), I will also be responsible for a collections fee of 40% of the principal amount(s) owing as allowed by California code. The terms of the paragraph shall apply to all the amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today. I also agree to the office contacting me through email/text messaging in regards to my account.

Responsible party's name (print): _____ **Date:** _____

Responsible party's signature: _____

Relationship to patient (if patient is a minor): _____