UP VALLEY
PEDIATRIC DENTISTRY
KIM NICHELINI, DMD • ANGELINA RING, DDS

176 Main Street #A
St. Helena, CA 94574

ph 707.968.5144
fax 707.302.5298

Patient Information

Today's Date: _____

Patient Information

Child's Name: _____ Nickname: _____ Male Female

Date of Birth: _____ Age: _____ School _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Child lives with: Both Parents Parent 1 Parent 2 Other

Whom may we thank for referring you? _____

Parent Information

Parent 1 Name: _____

Date of Birth: _____ Social Security No. (SSN): _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Parent 2 Name: _____

Date of Birth: _____ Social Security No. (SSN): _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Dental Insurance Information

Primary Insurance

Policy Owner's Name: _____ Relationship to Patient: _____

SSN: _____ Date of Birth _____

Insurance Co. Name: _____ Group Number _____

Insurance Co. Address: _____ Member Number _____

Secondary Insurance

Policy Owner's Name: _____ Relationship to Patient: _____

SSN: _____ Date of Birth _____

Insurance Co. Name: _____ Group Number _____

insurance Co. Address: _____ Member Number _____

Please turn over & complete other side

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Patient Information

Emergency Contacts

Name: _____ Relationship: _____

Main Phone: _____ Secondary Phone:: _____

Name: _____ Relationship: _____

Main Phone: _____ Secondary Phone:: _____

Mission Statement

It is our mission to work as a team with each family to deliver high-quality, individualized and comprehensive care in a gentle and empowering manner to provide the foundation for a lifetime of oral health.

Terms & Conditions

Insurance policies are contracts between you and the insurance company. To avoid misunderstandings regarding dental insurance, our professional services are charged directly to you, and you are personally responsible for payment of fees. This dental office will help prepare your child's insurance forms to assist in making collection from insurance companies, and will credit any such collections to your child's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

BROKEN APPOINTMENTS:

A failed appointment fee of $50.00 will be charged for all appointments that are broken without a 48-hour cancellation notice. I agree to pay this fee if I fail to properly notify the office in the event of a cancellation or no show. I also understand that two (2) consecutive broken appointments may lead to dismissal of my child as a patient.

WHAT WE DO:

- Provide you with an estimate of treatment and costs.
- Prepare and mail claims for patients.
- Send you an itemized statement each month of charges accrued.

WHAT WE EXPECT OF YOU:

- Provide complete and accurate information.
- Advise us of any changes to coverage or other patient information.
- Pay your estimated patient portion at the time of each appointment.
- Contact your insurance or employer if payment is not received within 60 days of treatment.
- Forward to us insurance checks that are sent to you if you have a balance due in our office.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes. I have read the above "TERMS AND CONDITIONS" and fully agree to their content I hereby authorize the office of Up Valley Pediatric Dentistry to proceed with evaluation and treatment of my child.

Signature of Parent/Guardian **Relationship** **Date**

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Patient Medical History

Today's Date _____

Patient Name _____ Birthdate _____

Your answers to this medical history form are for our records only and will be considered confidential.

Medical History

Child's Physician: _____

Phone: (_____) _____ Date of last visit: _____

Address: _____

City: _____ State _____ Zip _____

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

_____

Is your child up to date on their immmunizations? 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: _____

Is there anything you would like to discuss with the doctor in private? Yes No

Has your child had / experienced any of the following: (please circle)

Y	N	Behavior/Learning Disabilities	Y	N	Asthma	Y	N	Heart Murmur
Y	N	Developmental Delays	Y	N	Breathing or Lung Problems	Y	N	High/Low Blood Pressure
Y	N	Premature Birth	Y	N	Seasonal Allergies	Y	N	Diabetes
Y	N	Cerebral Palsy	Y	N	Hives or Rashes	Y	N	Endocrine System Disorders
Y	N	Down Syndrome	Y	N	Anaphylaxis	Y	N	Epilepsy or Seizures
Y	N	Autism/Asperger's Syndrome	Y	N	Eczema	Y	N	Kidney/Bladder Disease
Y	N	ADD/ADHD	Y	N	HIV/AIDS	Y	N	Liver Disease/Hepatitis
Y	N	Anxiety/Depression	Y	N	Immunocompromise	Y	N	GI Problems
Y	N	Sensory Issues	Y	N	Anemia	Y	N	Cancer/Tumors
Y	N	Speech Delay/Disorder	Y	N	Hemophilia or Bleeding Disorder	Y	N	Hospital stay(s)
Y	N	Hearing or Vision Impairment	Y	N	Congenital Heart Defect	Y	N	Operation(s)
						Y	N	Other

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

_____

Please Turn Over & Complete Other Side

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Patient Medical History

Dental History

Is your child currently in pain? Yes No Is this your child's first dental visit? Yes No

Has you child experienced problems with previous dental work? Yes No

If so, explain: _____

Previous Dentist: _____

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

Have there been any injuries to your child's teeth or jaws? Yes No

Does your child take fluoride supplements or drink fluoridated water? Yes No

Has your child been seen by an orthodontist? Yes No Who? _____

Does your child brush his / her teeth daily? Yes No Does he / she receive parental help? Yes No

Does your child floss his / her teeth daily? Yes No Does he / she receive parental help? Yes No

Does your child have any of the following habits? (please circle)

Y	N	lip sucking	Y	N	tongue / cheek biting	Y	N	pacifier use
Y	N	nail biting	Y	N	chewing on objects	Y	N	bottle use
Y	N	thumb / finger sucking	Y	N	clenching / grinding teeth	Y	N	nursing
Y	N	tongue thrust	Y	N	mouth breathing			

Please discuss any other specific concerns: _____

_____

Signature of Parent/Guardian Relationship Date

_____

Signature of Dentist Date

Notes

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CONSENT AND ACKNOWLEDGEMENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Child(ren) Name: _____ Date _____

SECTION A: TO THE PARENT FOR THE MINOR CHILD - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY
Purpose 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 health 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, explains the uses and disclosures we may make of your protected health information, and other important matters. A copy of our Notice is available to you at your request. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices as permitted by applicable law, 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 revision of our Notice, at any time by contacting: **Up Valley Pediatric Dentistry, 176 Main Street #A, St. Helena, CA 94574 T: 707.968.5144**

SECTION B: CELL PHONE
I consent to the dental practice using my cell phone to call/text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

☐ Yes ☐ No

My cell phone number is _____

SECTION C: EMAIL
I understand that unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to, or intercepted by unauthorized third parties.
I consent to receive email from us regarding, but not limited to treatment, insurance, and account information. We will use the minimum necessary amount of protected health information in any communication.

☐ Yes ☐ No

Email address:_____

SECTION D: SIGNATURE AND ACKNOWLEDGEMENT
I have had full opportunity to read and consider the contents of the Consent from and your Notice of Privacy Practices and I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, insurance, account information, and healthcare operations only.

Signature: _____ Date: _____

☐ Yes, I would like a copy of your Privacy Practices ☐ No, I do not wish to receive a copy of your Privacy Practices

Privacy Practices Policy

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Patient Informed Consent

INFORMED CONSENT FOR ROUTINE DENTAL PROCEDURES

As the patient's parent/legal guardian you have the right to accept or reject dental treatment recommended by the dentists at Up Valley Pediatric Dentistry. Prior to consenting to treatment, you should carefully consider the anticipated benefits, and commonly known risks of the recommended procedure, alternative treatment, and the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your child's dentist. We want to make sure all your concerns are addressed. By consenting to the treatment, you are acknowledging your willingness to accept risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide Dr. Kim Nichelini or Dr. Angelina Ring with accurate information before, during, and after treatment. It is equally important that you follow our doctor's advice and recommendations regarding medication, pre-and post op treatment instructions, referrals to other dentists or specialists, and that you return for scheduled appointment times. If you fail to follow their advice, you may increase the chances of a poor outcome.

Please read and initial the items below and sign the bottom of the form.

1. **TREATMENT TO BE PROVIDED:** I understand that during my child's course of treatment the following may be provided: Examinations, preventative services (fluoride, sealants, and space maintainers), restorations (fillings or crowns), extractions, and radiographs (x-rays). I will be consulted prior to each to procedure.

   Initial _____

2. **DRUGS AND MEDICATIONS:** I understand that antibiotics, anesthetic agents and other medications may cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction).

   Initial _____

3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were not discovered during examination. The most common changes are root canal therapy and extraction, following routine restorative procedures. I give my permission to my child's dentist to make any/all changes and additions as necessary. I understand that I will be consulted regarding changes whenever possible.

   Initial _____

Parent/ Legal Guardian Signature _____ Date _____