CHRISTIAN K. LEE, DDS, MS

BOARD CERTIFIED PEDIATRIC DENTIST

4149 El Camino Way, Ste B | Palo Alto, CA 94306
Office: 650.289.9200 | Fax: 650.289.9582
Website: www.youngteeth.com

PATIENT INFORMATION

Family Last Name:		Number of Family Members:	
Address:	City | State | Zipcode:		
1st Child's Name:	Nickname:	Date of Birth:	❑ Male ❑ Female
2nd Child's Name:	Nickname:	Date of Birth:	❑ Male ❑ Female
3rd Child's Name:	Nickname:	Date of Birth:	❑ Male ❑ Female

PARENT | GUARDIAN INFORMATION

Name (First, Last):		Relation: ❑ Father	❑Mother ❑ Guardian
Date of Birth:		Social Security #:	
Address:	City | State | Zipcode:		
Cell #:	Home #:	Work #:	Extension:
Email:			
❑ Single	❑ Married	❑ Seperated	❑ Widowed ❑ Partner

Name (First, Last):		Relation: ❑Father	❑Mother ❑ Guardian
Date of Birth:		Social Security #:	
Address:	City | State | Zipcode:		
Cell #:	Home #:	Work #:	Extension:
Email:			
❑ Single	❑ Married	❑ Seperated	❑ Widowed ❑ Partner

RESPONSIBLE PARTY

With whom does the patient(s) live with?	Person who is responsible for account?

INSURANCE INFORMATION

❑ **No dental insurance, responsible for paying Out of Pocket (Please read the Payment Policy Form)**

Primary Insurance	Secondary Insurance
Subscriber Name:	Subscriber Name:
Insurance Company:	Insurance Company:
ID Number:	ID Number:
Group #:	Group #:
Employer:	Employer:

Whom may we thank for referring you to our office?

❑ I have reviewed the information on this form and it is accurate to the best of my knowledge. It is my responsibility to update the dental office of any changes in our personal information and insurance information.

Signature of Parent | Guardian: _____ **Date:** _____

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DENTAL HISTORY

Patient Name:	Date of Birth:
Reason for Today's visit:	
Former Dentist:	Office Phone:
Address:	City | State | Zipcode
Date of Last Dental Care:	Date of Last Dental X-Rays:

Please check if your child has problems with any of the following:

- ❑ Bad breath
- ❑ Bites or chews nails
- ❑ Clenches Jaw | Grinds Teeth
- ❑ Food collection between teeth
- ❑ Gags easily
- ❑ Loose Teeth
- ❑ Sensitivity to hot |cold
- ❑ Snores | Wakes up unrested
- ❑ Sores or growths in mouth
- ❑ Sucks thumb or fingers
- ❑ Sucks or bites lips
- ❑ Takes fluoride supplements

Was your child breast fed? ❑ Yes ❑ No Till age? _____

Was your child bottle fed? ❑ Yes ❑ No Till age? _____

How often does your child brush? ❑ Once a day ❑ Twice a day ❑ Other _____

How often does your child floss? ❑ Once a day ❑ Twice a day ❑ Other _____

Has your child had difficulty with other dental visits? ❑ Yes ❑ No Describe: _____

MEDICAL HISTORY

Pediatrician's Name:	Office Phone:
Date of Last Physical:	

Has your child had any serious illness or operations? ❑ Yes ❑ No Describe: _____

Please check if your child has or had any of the following:

- ❑ AIDS | HIV Positive
- ❑ Anemia
- ❑ Asthma
- ❑ Autism
- ❑ Bleeding Disorder
- ❑ Blood Diseases
- ❑ Cancer
- ❑ Cerebral Palsy
- ❑ Development Delay
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fevers
- ❑ Heart Problems
- ❑ Hepatitis
- ❑ Herpes Virus
- ❑ Mental Disorder
- ❑ Nervous
- ❑ Speech Disorder
- ❑ Vision Disorder

MEDICATIONS |ALLERGIES

Current medications your child is taking _____

Please check if your child has allergies with any of the following:

- ❑ Aspirin
- ❑ Latex
- ❑ Local Anesthesia
- ❑ Nuts
- ❑ Penicillin
- ❑ Sulfa
- ❑ Other: _____ _____

❑ The above information is accurate and complete to the best of my knowledge. I understand that providing incorrect information can put my child's health at risk and it is my responsibility to inform the dental office of any changes in my child's medical status. I will not hold my dentist or any members of his staff responsible for any errors or omissions that I may have made in completion of this form.

Signature of Parent | Guardian: _____ **Date:** _____

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PAYMENT POLICY

Thank you for choosing us as your primary dental provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance.** We participate in most insurance plans. If you are not insured by a plan we are contracted with, payment in full is required on date of service. If you are insured by a plan we are contracted with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid on the day you make a treatment appointment unless other arrangements have been made with our office. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non covered or not considered reasonable or necessary by other insurers. You must pay for these services in full at the time of visit.
4. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. You may be subject to pay out-of-pocket if your insurance is not verified on the day of your appointment. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
7. **Nonpayment.** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative dental care. During that 30-day period, our physician will only be able to treat you on an emergency basis.
8. **Missed appointments.** Our policy is to charge $50.00 per child for missed appointments not canceled within a reasonable amount of time of 48 hours. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

As a health care provider, we are ethically driven to make honest recommendations based upon what we feel is best for your child's health, not based on what your insurance will cover. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

❑ I have read and understand the payment policy and agree to abide by its guidelines:

Signature of Responsible Party: _____ **Date:** _____

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CELL PHONE CONSENT

❑ I consent to the dental practice using my cell phone number to call regarding treatment, insurance, and my personal account and|or text regarding appointments. I understand that I can withdraw from my consent at any time.

Cell Phone (Including Areacode): _____ **Initials:** _____

Our federal and state rules govern telemarketing and commercial email messages. A summary of these laws is available on the website of the Office of the Attorney General at oag.ca.gov/privacy/privacy-laws.

ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

I, _____ [Full Name] acknowledge that the Materials Fact Sheet, describing the materials we use in this office, has been made available to me.

❑ I have received a copy of the Dental Materials Fact Sheet.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement ❑ **Declined**

I, _____ [Full name], have received a copy of Christian K. Lee, DDS, MS Notice of Privacy Practices.

Signature: _____ **Date:** _____

If this acknowledgement is signed by a personal representative on behalf of the patient, complete the following.

Personal Representatives Name: _____

Relationship to Patient: _____ **Date:** _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

❑ Individual refused to sign
❑ Communications barriers prohibited obtaining the acknowledgement
❑ An emergency situation prevented is from obtaining acknowledgement
❑ Other (Please Specify) _____