PATIENT INFORMATION *Informacion Sobre Paciente*

DATE *Fecha* _____ PATIENT'S NAME *Nombre del Paciente* _____ LAST *(Apellido)* _____ FIRST *(Nombre)* _____ MIDDLE *(Inicial)* _____

ADDRESS *Dirección* _____ STREET *(Calle)* _____ CITY *(Ciudad)* _____ STATE *(Estado)* _____ ZIP *(Zona Postal)* _____

HOME PHONE *Teléfono* _____ SOCIAL SECURITY # *# de Seguro Social* _____ DRIVER'S LICENSE # *# de Licencia de Manejar* _____

BIRTHDATE *Fecha de Nacimiento* _____ IF PATIENT IS A MINOR, GIVE PARENT'S / GUARDIAN'S NAME. *Si el paciente es menor de edad, pónga el nombre del padre o tutores.* _____

EMERGENCY CONTACT *En caso de Emergencia, con quién comunicarse* _____ TELEPHONE *Teléfono* _____

RESPONSIBLE PARTY INFORMATION *Informacion de la Persona Responsable*

NAME *Nombre* _____ LAST *(Apellido)* _____ FIRST *(Nombre)* _____ MIDDLE *(Inicial)* _____ MARITAL STATUS *Estado Civil* _____

MAILING ADDRESS *Dirección* _____ STREET *(Calle)* _____ CITY *(Ciudad)* _____ STATE *(Estado)* _____ ZIP *(Zona Postal)* _____

SOCIAL SECURITY # *# de Seguro Social* _____ BIRTHDATE *Fecha de Nacimiento* _____ RELATIONSHIP TO PATIENT *Relación del Paciente* _____

EMPLOYER *Empleador* _____ OCCUPATION *Ocupación* _____ NO. OF YEARS EMPLOYED *Cuántos Años en su empleo* _____

EMPLOYER'S ADDRESS *Dirección de su empleador* _____ TELEPHONE *Teléfono* _____

INSURANCE INFORMATION *Informacion de Aseguranza*

INSURED'S NAME *Nombre del Asegurado* _____ SOCIAL SECURITY # *# de Seguro Social del Asegurado* _____

INSURANCE COMPANY *Compañía de Aseguranza* _____ GROUP NO. *Número del Grupo* _____

INSURANCE CO. ADDRESS *Dirección de la Compañía de Aseguranza* _____ TELEPHONE *Teléfono* _____

INSURED'S EMPLOYER *Empleador del Asegurado* _____ TELEPHONE *Teléfono* _____

PHYSICIAN INFORMATION *INFORMACION DEL MEDICO*

PHYSICIAN NAME
Nombre del medico _____ PHYSICIAN PHONE NUMBER
Numero de telefono del medico _____

PHYSICIAN ADDRESS
Direccion del medico _____

DENTAL INFORMATION *Informacion Dental*

DO YOUR GUMS BLEED WHEN YOU BRUSH? *Sangran sus encias cuando se sepilla?* ..... YES *SI* NO *NO*

ARE YOUR TEETH SENSITIVE TO HEAT OR COLD? *Son sensitivos sus dientes a lo caliente o al frío?* ..... YES *SI* NO *NO*

DATE OF LAST DENTAL EXAMINATION *(Cuándo fué su último examen dental?)* _____

HOW WOULD YOU DESCRIBE YOUR CURRENT DENTAL PROBLEM *En éste momento, como podrá describir su problema dental?* _____

MEDICAL INFORMATION *Condicion Medica*

1. ARE YOU HAVING PAIN OR DISCOMFORT AT THIS TIME? *Está sintiendo dolor o molestia en este momento?* ..... YES *SI* NO *NO*
2. HAVE YOU BEEN A PATIENT IN A HOSPITAL DURING THE PAST TWO YEARS? *Ha sido hospitalizado durante los últimos dos años?* ..... YES *SI* NO *NO*
3. HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS? *Ha estado bajo atención média con un doctor durante los últimos dos años?* ..... YES *SI* NO *NO*
4. ARE YOU NOW TAKING ANY MEDICATION OR DRUGS? *Está usted presentamente tomando alguna medicina o droga?* ..... YES *SI* NO *NO*

   IF YES, PLEASE LIST *(Si contestó Sí, por favor indique):*
5. ARE YOU SENSITIVE OR ALLERGIC TO ANY MEDICATION OR ANESTHETICS? *Es usted alérgico a algún medicamento o a la anestesia?* ..... YES *SI* NO *NO*

   IF YES, PLEASE LIST *(Si contestó Sí, por favor indique):*
6. INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT. (Circle "Yes or No" to Each Item)
   Indique cual de los síntomas ha tenido o tiene presentemente. (Circule "Si o No" tal como corresponde.

Heart Disease or Attack *Ataques de corazón o problemas*	YES	NO	Diabetes *Diabetis*	YES	NO	A.I.D.S. *S I D A*	YES	NO
Angina Pectoris *Angina de Pecho*	YES	NO	Tuberculosis *Tuberculosis*	YES	NO	H.I.V. Positive *H.I.V. Positivo*	YES	NO
Heart Murmur *Soplo del corazón*	YES	NO	Asthma *Asima*	YES	NO	Cold Sores / Fever Blisters *Ampoyas o Fiebre*	YES	NO
High Blood Pressure *Alta Presión*	YES	NO	Allergies or Hives *Alergias o Ronchas*	YES	NO	Blood Transfusion *Transfusión de Sangre*	YES	NO
Rheumatic Fever *Fiebre Reumática*	YES	NO	Sinus Trouble *Problemas de Sinusitis*	YES	NO	Liver Diease *Enfermedad del Higado*	YES	NO
Arthritis *Artritis*	YES	NO	Radiation Therapy *Terapia de Radiación*	YES	NO	Yellow Jaundice *Vilis*	YES	NO
Rheumatism *Reumatismo*	YES	NO	Hepatitis-A (Infection) *Hepatitis-A (Infección)*	YES	NO	Epilepsy or Seizures *Ataques o Epilepsia*	YES	NO
Stroke *Embolio*	YES	NO	Hepatitis-B (Serum) *Hepatitis-B*	YES	NO	Nervousness *Nerviosismo*	YES	NO
Kidney Trouble *Problemas de Rinoñes*	YES	NO	Venereal Disease *Enfermedades Venereas*	YES	NO	Developmentally Disabled *Mentalmente Desabilitado*	YES	NO
						Allergic to Latex	YES	NO

7 DO YOU HAVE OR HAVE YOU HAD ANY DISEASE, CONDITION OR PROBLEM NOT LISTED?
Ha tenido o tiene enfermedad, condición o problema que no fue indicada?

IF YES, PLEASE LIST *(Si contestó Sí, por favor indique)*:_____

FOR WOMEN ONLY *Para la Mujer Solamente*

ARE YOU PREGNANT? ☐ YES ☐ NO *Está embarazada? Si No*

WHAT MONTH_____ *Qué Mes*

ARE YOU NURSING ☐YES ☐NO *Está Amamantando?*

ARE YOU TAKING BIRTH CONTROL PILLS? ☐YES ☐NO *Está tomando pastillas anti-conceptivas? Si No*

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TRUTHFULLY AND TO THE BEST OF MY KNOWLEDGE.

Yo entiendo que la información anterior es para darme tratamiento dental en una forma eficiente y segura. He contestado todas las preguntas de acuerdo a mi conocimiento.

PATIENT SIGNATURE_____ DATE_____
Firma del Paciente *Fecha*

CONSENT *Consentimiento*

1 THE UNDERSIGNED HEREBY AUTHORIZES DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDES DEEMED APPROPRIATE BY DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS.

2 I ALSO AUTHORIZE DOCTOR TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME AND TO USE THE APPROPRIATE MEDICATION AND THERAPY INDICIATED FOR SUCH TREATMENT IN CONNECTION WITH:
NAME OF PATIENT_____
I UNDERSTAND THAT USING ANESTHETIC AGENTS EMBODIES A CERTAIN RISK. FURTHERMORE, I AUTHORIZE AND CONSENT THAT THE DOCTOR CHOOSE AND EMPLOY SUCH ASSISTANCE AS DEEMED FIT TO PROVIDE RECOMMENDED TREATMENT.

3. I UNDERSTAND THAT ALL RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE, DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE. IN THE EVENT PAYMENTS ARE NOT RECEIVED BY THE AGREED DATES, I UNDERSTAND THAT A 1-1/2% FINANCE CHARGE (18% APR) MAY BE ADDED TO MY ACCOUNT, IN ADDITION TO ANY COLLECTION CHARGES.

4. I UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

5. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO ADVISE YOUR OFFICE OF ANY CHANGES IN THE INFORMATION CONTAINED ON THIS FORM.

PATIENT_____ DATE_____
Paciente *Fecha*

WITNESS_____
Testigo

PARENT OR RESPONSIBLE PARTY_____ RELATIONSHIP TO PATIENT_____
Padre o Persona Responsable *Relación al Paciente*

FOR OFFICE USE ONLY

REVIEWED BY DR._____ DATE_____

HIPAA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I have been provided with a copy of the *Notice of Privacy Practices* that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this faciliy's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- this facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.

X Signature of Patient or Legal Representative Witness .....

Printed Name of Patient or Legal Representative Witness .....

Date: .....

Kids R Us Dental & Adult Dentistry

HEALTH HISTORY & PATIENT INFORMATION UPDATE FORM/ HISORIAL DE SALUD Y INFORMACION DE PACIENTE

DATE/FECHA: _____ DATE OF BIRTH/FECHA DE NACIMIENTO: _____

PATIENT'S NAME/NOMBREDEL PACIENTE: _____

ADDRESS/DIRECCION: _____

EMAIL ADRRESS/CORREO ELECTRONICO: _____

PHONE NUMBER/ TELEFONO: _____ MOBLIE/CELULAR: _____

EMERGENCY PHONE NUMBER/TELEFONO DE EMERGENCIA: _____

ARE THERE ANY CHANGES IN YOUR HEALTH/HA HABIDO CAMBIOS EN SU SALUD: YES/SI ☐ NO ☐

IF YES PLEASE SPECIFY/ SI SU RESPUESTA ES SI POR FAVOR DE ESPLICAR: _____

_____

PHYSICAN'S NAME/NOMBRE DE SU DOCTOR MEDICO: _____

PHYSICIAN'S PHONE NUMBER/NUMERO DE SU DOCTOR MEDICO: _____

ARE YOU ALLERGIC TO LATEX? / ES USTED ALERGICO AL LATEX?: YES/SI ☐ NO ☐

HAVE YOUR INSURANCE INFORMATION CHANGED? / HA HABIDO CAMBIO CON SU ASEGURANZA?

YES/SI ☐ NO ☐

IF YES, PLEASE SPECIFY/SI SU RESPUESTA ES SI POR FAVOR DE ESPLICAR: _____

_____

PATIENT/PARENT'S SIGNATURE/FIRMA DEL PACIENTE/PADRES: _____

DENTIST'S SIGNATURE/ FIRMA DEL DENTISTA: _____

Kids R Us Dental & Adult Policies

Effective December 1st, 2018 Kids R Us Dental and Adult Dentistry has updated.

Our office policies for all patients, should you be interested in more information regarding our policy updates please ask a member of our staff!

***Cancellation/ Rescheduling Policy**

We require a minimum of (2) business day notice for any rescheduling. While we understand that sometimes situations are outside of your control, we strive to show courtesy to all of our parents and families, including those who are on a waiting list for your appointment time. Please note that a broken appointment fee is applied per appointment time slot, not per family. For example for a broken appointment for two children on a Saturday, you will be responsible for $75.00 x 2 = $150.00

Our fees for notice with less than (2) business day notice are as follows:

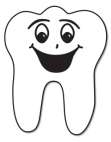
- $50 for a cleaning appointment
- $75 for a Saturday appointment
- $150 for a broken treatment appointment and a deposit will be required for any future scheduled treatment.

We thank you for your understanding as we incorporate these new policies to our dental office.

Kindest Regards,

The Staff at Kids R Us Dental and Adult Dentistry

X_____ Date: _____



Kids R Us Dental

325 Old Newport Blvd. Newport Beach, CA 92663 Phone: 949-873-5710

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. Obtaining payment from third payers (e.g. my insurance company)
3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used an disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name: _____

Relationship to Patient: _____

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

INSURANCE BENEFITS DISCLAIMER

Please read, initial and sign

Many insurance companies cover some dental procedures. We will be happy to file your insurance claim for you and do all we can to ensure we receive reimbursement. However, we cannot take responsibility for what your dental insurance will or will not cover. It is the policy of Kids R Us Dental to not enter dispute with your insurance company.

I understand that the service Kids R Us Dental provides for verification for insurance coverage is in no way a promise of payment by my insurance company. If my insurance company denies my claim(s) for any reason, or misquotes my benefits, to Kids R Us Dental the balance of my account will be billed to me and due to Kids R Us Dental._____
Initial here

I understand that if I choose to use my insurance coverage I will be responsible for any co-pays, deductibles and uncovered fees based on my insurance Explanation of Benefits._____
Initial here

ASSIGNMENT OF BENEFITS

I understand that my signature below indicates my acceptance of all the information presented on this page. I also understand that my signature below serves as a "signature on file" to bill the insurance company I have provided information for and allows Kids R Us Dental to accept assignment of insurance benefits._____
Initial here

Patient: _____ _____

Parent / Guardian Signature