Kid's Dental Care

Bruce B. Baker, D.M.D.
Poway Office: 13422 Pomerado Rd #201
Poway, California 92064
Phone:(858)679-6660 Fax:(858)679-8580

Pediatric Dentistry
Temecula Office: 42210 Lyndie Lane #100
Temecula, California 92591
Phone:(951)506-1666 Fax:(951)506-1674

PATIENT COMMUNICATION:

We provide our patients the option to participate in our online patient communication system. Some key features include the ability to:

• Request appointments online
• Confirm appointments via e-mail
•Receive text messaged appointment reminders
•Submit patient satisfaction surveys and reviews
•Refer your family and friends to our office

*You may OPT OUT from this communication method at any time by clicking the UNSUBSCRIBE link found in the footer of each e-mail, or by replying to a text message with STOP. Please note that standard text message rates will be applied.

PLEASE VERIFY YOUR CONTACT INFORMATION:

Cellular Phone #:_____
Check here to OPT-IN to text:_____

E-mail Address:_____@_____
Check here to OPT-IN to e-mail:_____

We use this information to provide you with additional methods of communication. We may disclose Patient Health Information (PHI) to third parties that perform services for Kid's Dental Care in the administration of your benefits, in accordance with HIPAA. These parties are required by law to sign a contractual agreement to protect the confidentiality of your PHI.
Our affiliates DO NOT sell, share, or rent our user's personally identifiable information unless required by law, and WILL NOT deliver any e-mails or communications without user permission.

Please sign below that you agree to allow us to utilize this information in providing your services.

Signature Today's Date

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Establishment of Financial Responsibility:

A representative from our front office staff will provide you with an estimate of your total charges prior to your child's visit. This estimate is based on the information that our office received when verifying active coverage and benefit information directly from your dental insurance carrier. The information obtained is in direct correlation with your contract specifics, however please note it is **NOT** a guarantee of payment.

Once in-office services are rendered you will be asked to pay your deductible, co-payment, and/or co-insurance. As a courtesy, we will then bill your dental insurance company on your behalf. While each insurance company is different, we generally expect payment to be received **within 60 days of claim submission**. If payment is not received we will then send notification of their non-payment with a billing statement and request that you contact them directly**. In the instance of non-payment, please note YOU will then be held financially responsible for any balance due.**

We ask that you claim full responsibility for knowing the specifics of your insurance contract. Examples of these specifics include but are not limited to: copays, deductibles, pre-authorizations, covered and non covered services and policy maximums. If you have any questions regarding in- office insurance verification, the claims submission process or your financial responsibilities please let our front office staff know so that we may further assist you.

I have reviewed the above information and I am aware that if my insurance company does NOT release payment for services rendered that I will be held financially responsible for any and all incurred balance due.

Signature of Parent/Guardian:_____Date:_____

Patient:_____

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EXPLANATION OF OFFERED SERVICES

X-RAYS: (Radiography)

Benefits:
• Can detect hidden problems • Offer a more accurate diagnosis to better determine treatment needs
Possible Complications:
• Exposure to radiation (risk level: minimal)
Consequences of Postponing Films:
• Undetected problems • Unable to perform necessary dental services

CLEANING/SCALING:

Benefits:
• Cosmetic enhancement • Clean mouth • Prevention of gum disease •Odor elimination
Possible Complications:
• Sensitive teeth and gums • Enhanced feeling of spaces between teeth • May loosen fillings (Normal if filling was already loose)
Consequences of Postponing Treatment:
• Stains on teeth • Odors • Gum disease •Will lose teeth sooner

LOCAL ANESTHETICS:

Benefits:
• Pain avoidance during procedures and treatment
Possible Complications:
• Prolonged numbness extending beyond normal range • Nerve damage • Bruising (Hematoma) • In rare instances, may include all those applicable to general reactions up to and including death
Consequences of Postponing Usage:
•Mild to severe pain during and after treatment

NITROUS OXIDE: (Recommended for children 7 and under)

Benefits:
•Helps patient to relax • Helps reduce anxieties associated with dental visits • Decreases sensitivity to pain
Possible Complications:
Can upset stomach, naseau, and vomiting

BONDED FACING:

Benefits:
• Aesthetics- they look nice • Cover crooked and/or discolored teeth •Close spaces and gaps
Possible Complications:
• Edges can stain after time and need to be refreshed (Additional fees apply) • Breakage can occur, resulting in the need for remake • Difficult to remove

FILLINGS: (Composite/ Amalgam)

Benefits:
• Eliminates Decay • Pain Relief •Fills in hole or space in tooth •Covers eroded areas •Protects sensitive surfaces
Possible Complications:
•Tooth may abscess (a localized infection) from the filling • Tooth may fracture • Tooth may be sensitive to temperature changes • Amalgam (silver filling) may release mercurial toxicity
(Please ask for California Proposition 65 for more information) • Fillings may fall out
Consequences of Postponing Treatment:
• May lose tooth • Tooth may fracture • Decay will worsen • Increased pain and sensitivity • May result in root canal
Treatment Alternatives:
• Temporary filling • Extraction

EXTRACTIONS:

Benefits:
• Last resort for a non-salvageable tooth • Eliminate pain • Remove teeth that are out of position •Eliminate infection
Possible Complications:
• Fractured particles may remain • Irritation to nerves may cause temporary or permanent numbness • Partial or entire tooth may be lodged in sinus cavity requiring additional surgery • Severe infections may take longer to clear up • Jaw may be stiff and difficult to open for a time • If jaw bone is weak, it may fracture
Consequences of Postponing Treatment:
• Infection can spread • Pain • Swelling

CROWNS-CAP

Benefits:
• Cosmetic enhancement • Repairs a severely broken down tooth • Prevents tooth from fracturing •Restores a broken tooth
Possible Complications:
•Porcelain portion of crown may fracture • Crown may come off and require re-cementing • Tooth may abscess and require further treatment • Future decay may require a filing or new crown
Consequences of Postponing Treatment:
•Tooth will fracture • Tooth may require extraction • May require root canal in addition to crown
Alternatives:
•Steel Crown • Extraction

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Guardian Information:

Guardian Name:_____
Guardian DOB:_____Guardian SSN:_____
Guardian Address:_____
Apt#:_____ City:_____ State:_____
Zip Code:_____ * NO P.O. BOX, PLEASE*
Contact Phone# :Home: _____Cell:_____
Guardian Relationship to Child: ( )Mother ( )Father
( )Other:_____

Insurance Payment Release Form:

Patient Name:_____
Subscriber Name:_____
Subscriber ID:_____
Insurance Company:_____

I,_____, hereby authorize and direct payment of dental benefits otherwise payable to me, directly to the rendering dental provider, Dr. Bruce B. Baker. I have been informed of the treatment plan and associated fees, and agree to be financially responsible for all charges for dental services and materials not covered by my dental benefit plan, unless prohibited by law or if the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activites in connection with this claim.

Print Name:_____Date:_____

Signature:_____

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INFORMED CONSENT FOR DENTAL SERVICES

I hereby consent to the performance of routine dental procedures and/or dental treatment that my child will be receiving that may include, but is not limited to the following services:

Radiography, Cleaning and Scaling, Local Anesthetics, Nitrous Oxide Usage, Composite/Amalgam Fillings, Bonded Facing, Extractions, and Crowns/Capping. (Please ask for additional information regarding the above listed procedures)

These treatments will be performed by a licensed Doctor of Pediatric Dentistry (Pedodontist) and General Anesthesiologist (when applicable),in collaboration with licensed dental assistants who now or in future situations will treat my child while employed by, working for, or associated with the office named below.

I have had the opportunity to discuss with Bruce B. Baker, DMD APDC/ Kid's Dental Care and/or any other office or clinical personnel the nature and purpose of routine dental visits and treatment.

I understand and am informed that as in the practice of medicine, in the practice of dentistry there are some risks to treatment. I do not expect the doctor to be able to anticipate and explain all risks and complications that may arise, and I wish to rely on the doctor to exercise sound judgement during the course of any procedure which the doctor feels at the time, is in my child's best interest.

I have read or have had read to me, the above consent. I have also had the opportunity to ask questions about its content, and by signing below I agree to the above named procedures. I intend for this consent form to cover the entire course of treatment for my child's present condition and for any future condition(s) for which I seek services on their behalf.

Patient's Name:_____Date:_____

Signature of Parent/Guardian:_____

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HOW CAN WE IMPROVE?

It is our commitment that patients come first at Kid's Dental Care. We appreciate your business and would like your feedback on your child's visit, our office, and our overall performance. Please take a moment to help us improve your experience in Dr. Baker's office.

On a 5 star scale, how would you rate your overall experience? Please check the number of stars correlating with your visit (5 being the highest, 1 being the lowest).

Additional Comments:

Name:_____

Date:_____ Email:_____

THANK YOU FOR YOUR PARTICIPATION!

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PATIENT INFORMATION:

(Informacion del Paciente)

Child's Name (Nombre del Nino/Nina):_____**Nickname(Apodo):**_____

Family Name(Apellido):_____**Male/Female**

Birthdate(Fecha de Naciemiento):_____ **Age(Edad):**_____

Home Address (Direccion de la Casa):_____
(Calle) (Ciudad) (Postal)

Secondary Address (Dirrecion de la Casa):_____
(Calle) (Ciudad) (Postal)

Home Phone # (Telefono de la Casa):_____

Is this your child's 1st dental visit? Y/N Are any other members of your family current patients? Y/N

FAMILY INFORMATION:

(Son Pacientes Informacion de Familia)

Fathers Name (Nombre del Padre):_____

Name of Employer (Nombre del Empleador):_____**City (Ciudad):**_____

Occupation (Ocupacion):_____**Business Phone (Telefono de Trabajo):**_____

Mothers Name (Nombre de la Madre):_____

Name of Employer (Nombre del Empleador):_____**City (Ciudad):**_____

Occupation(Ocupacion):_____**Business Phone (Telefono de Trabajo):**_____

INSURANCE INFORMATION:

(Informacion Aseguransa)

Insurance Carrier (Nombre de Aseguransa):_____**PolicyHolder (El titular de la poliza):**_____

Subscriber ID#(de ID Subscriptor):_____ **Subscriber DOB (Fecha de Nacimiento):**_____

Subscriber SS# (Seguro social de suscriptor):_____**Childs SS# (de Seguro Social):**_____

EMERGENCY CONTACT:

(Contacto de Emergencia)

Name (Nombre):_____

Phone Number (Nombre de Telefono):_____**Relationship to Child (Relacion con el Paciente):**_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

(A quien le damos las gracias por recomendarlo a esta oficina)

_____

Signature of Parent/Guardian (Firma):_____**Date (Fecha):**_____

PATIENT MEDICAL INFORMATION:

(INFORMACION MEDICA DEL PACIENTE)

Is there now, or has there ever been history of the following?

(Senala si hay o si a habido alguno de los siguientes)

Toothache (dolor de dientes)	**Pain** (dolor)	**Broken Tooth** (dientes rotos)	**Extracted Teeth** (extraccion de dientes)	**Gum Infection** (infeccion en la encia)

Is child: Under care of physician now (esta su nino bajo cuidado medico**)? Y/N** **Why (**Por que**)?**_____

Taking Medication (Esta tomando algun medicamento**)? Y/N (please list types of medication)** _____

_____

Physician Name (Nombre del Medico**):**_____**Phone** (Telefono**):**_____

Last Medical Exam: Date (Pulgadas**):**_____**Reason (**Motivo**):**_____

Height (Altura**):**_____**Weight** (Peso**):**_____ **Birth Weight** (Peso al nacer**):**_____

Was child born of a normal (9) month pregnancy term (Nacio el nino de un embarzo normal de 9 meses**): Y/N**

If premature, how many months (Si fue premature de cuantos meses**)?**_____

Has child ever been hospitalized (Ha sido alguna vez hospitalizado el nino**)? Y/N** **Why (Por que)?** _____

Is child handicapped in any way (Tiene el nino algun tipo de impedimento fisico**)? Y/N**

Please explain:_____

Has child had abnormal bleeding tendencies (Ha tiendo alguna vez experiences de sangrado**)? Y/N**

ORGANS AND SYSTEMS:

Has child had any treatment involving the following?

(Alguna vez ha tenido el nino algun tralamiento para lo siquente) (PLEASE CIRCLE IF APPLICABLE)

Heart (Corazon**)** **Eyes,ears,nose,throat (**Ojos, Oidos, Nariz y Garganta**)** **Blood-Circulatory (**Circulacion de la Sangre**)**

Tonsil, adenolds(Amigdalas, Adenoide**)** **Endocrine Glands (**Glandulas Endocrinas**) Liver (**Higado**) Gastrointestinal (**Digestive**)**

Skin (Piel**)** **Bladder-Kidney** (Vajiga-Rinon**) Muscle** (Musculos**)** **Bones** (Huesos) **Nervous System** (Sistema Nervioso)

Respitory System (Sistema Respiratorio**) Other** (Otros):_____

ILLNESSES:

Has child ever been diagnosed with any of the below conditions?

(Alguna vez a sido diagnosticado el nino con alguna de las siguientes condiciones) (PLEASE CIRCLE IF APPLICABLE)

Scarlet Fever (Fiebre escarlatina) **Measles (Sarampion)** **Chicken Pox (**Varicel**a) Diphtheria** (Difteria) **Mumps (**Paperas)

Whooping Cough (Tosferina) **Mental Retardation** (Retraso Mental) **Cerebal Palsy** (Paralisis Cerebral**)** **Polio** **Tetanus** (Tetano)

Allergy (Alergia) **Asthma** (Asma) **Convulsions** (Convulciones) **Fainting** (Desmayos**)** **Hepatitus** **Autism** (Autismo) **Diabetes**

Emotional Disturbance (Disturbios Emocionales) **Rheumatic Fever** (Fiebre Reumatica) **Anemia** **Jaundice** (Ictericia)

HIV/AIDS **Excessive Bleeding** (Sangrado Excesivo) **Other**(Otros):_____

MEDICATION:

Has child had any unusual reactions to the following?

(Ha tiendo el nino alguna reaccion inusual a lo siguiente) (PLEASE CIRCLE IF APPLICABLE)

Allergy to Latex/Rubber **Local Anesthetic (Novacaine)** (Anestecia Local Novocaina) **Penicillin** (Penicilina)

Other Medicine or Foods (Otras Medicinas o Alimentos)_____

Does child have any special problems not listed above (Tiene el nino algun problema especial que no se halla nombrado)? **Y/N**

_____

_____

Parent/GuardianSignature:_____**Date:**_____