Kid's Dental Care

Bruce B. Baker, D.M.D. — Pediatric Dentistry

Poway Office: 13422 Pomerado Rd # 201
Poway, CA 92064
Phone: 858-679-6660 Fax: 858-679-8580

Temecula Office: 29645 Rancho California Rd #237
Temecula, CA 92591
Phone: 951-506-1666 Fax: 951-506-1674

PATIENT APPLICATION

Edad / **Age**_____ Fecha de Nacimiento / **Birthdate**_____

Nombre del Niño/Niña / **Child's Name:**_____ Apodo / **Nickname**_____ Apellido / **Family Name**_____

Nombre de Padre / **Father's Name**_____ Nombre de la Madre / **Mother's Name**_____

Direccion de la Casa / Calle / Ciudad / Postal

Home Address_____
Street **City** **Zip.**

Numero de Seguro Social del Padre
Subscriber's Social Security Number_____

Telefono de la casa / **Home Phone**_____ Numero de Seguro Social del Niño / **Child's SS No. Where Necessary**_____

Ocupacion del Padre / **Father's Occupation**_____ Telefono del Trabajo / **Business Phone**_____

Nombre del Empleador / **Name of Employer**_____ Ciudad / **City**_____

Ocupacion de la Madre / **Mother's Occupation**_____ Telefono del Trabajo / **Business Phone**_____

Nombre del Empleador / **Name of Employer**_____ Ciudad / **City**_____

Nombre de otros Niños en la familia y sus edades
Names of other children in the family and ages

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Es esta la primera visita del Niño al Dentista?
Is this your child's first visit to a dentist?_____

Algun otro miembro de su familia es paciente aqui?
Are any other members of your family patients here?_____

Señala si hay o si a habido alguna vez alguno se los siguientes? (Circular)
Is there now, or has there ever been any of the following? (Circle)

Dolor de Dientes	Dolor	Dientes rotos	Extraccion de dientes	Infeccion en la encia
Toothache	**Pain**	**Broken Tooth**	**Extracted Teeth**	**Gum Infection**

Esta su Niño bajo cuidado medico? / **Is child: Under care of physician now?**_____ Por que? / **For what?**_____

Es alergico a algun medicamento o sustancia? / Esta tomando algun medicamento
Taking any medicine?_____

Explique lo anterior
Explain the above_____

_____

_____

Nombre del Medico / **Name of physician?**_____ Telefono / **Phone**_____

A quien le damos las gracias por recomendarlo a esta oficina?
Who may we thank for referring you to our office?_____

Firma / **Parent/Guardian Signature**_____ Feche / **Date**_____

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Medical Information / Informacion Medica del Niño

Ultimo Examen medico: Fecha Motivo
Last medical examination: Date_____ **Reason**_____

Altura Pies Pulgadas Peso Lbs Peso al nacer Libras Onzas
Height_____**Ft**_____**Inches** **Weight**_____**lbs** **Birth Weight**_____**lbs**_____**oz**

	Si	No	
Nacio el niño de un embarazo normal de 9 mesas? **Was the child born of a normal 9 month term pregnancy?**	□ **Yes**	□ **No**	
Si fue premature de cuantos meses? Meses **If premature how many months?** _____**Months**			
Esta el nino siendo tratado bajo cuidado medico en el momento? **Is the child being treated by a physician now?**	□ **Yes**	□ **No**	Por que? **Why?** _____
Ha sido alguna vez hospitalizado el nino? **Has the child ever been hospitalized?**	□ **Yes**	□ **No**	Por que? **Why?** _____
Tiene el nino algun tipo de impedimento fisico? **Is the child handicapped in any way?**	□ **Yes**	□ **No**	Por que? **Why?** _____
Esta tomando el nino algun medicamento? **Is the child taking any medication now?**	□ **Yes**	□ **No**	Por que? **Why?** _____
Ha tenido alguna vez experiencias de sangrado? **Has the child ever experienced any bleeding tendencies?**	□ **Yes**	□ **No**	Por que? **Why?** _____

ORGANS AND SYSTEMS / Organos and sistemas

Alguna vez ha tiendo el nino algun tralamiento para lo siquente?
Has the child had any treatment involving the following?

Si **Yes**	No **No**	? **Unknown**	Si **Yes**	No **No**	? **Unknown**
□	□	□ Heart/ corazon	□	□	□ Eyes, ears, nose, throat/ Ojos, oidos nariz y garganta
□	□	□ Blood Circulatory/ circulacion de la sangre	□	□	□ Tonsils, adenoids/ Amigdalas, adenoide
□	□	□ Liver/ Higado	□	□	□ Gastrointestinal (digestive) / Gastrointestinal
□	□	□ Endocrine glands/ glandulas endocrinas	□	□	□ Skin / Piel
□	□	□ Bladder-kidney/ Vajina Rinon	□	□	□ Muscle/ Musculos
□	□	□ Nervous system/ Sistema nervioso	□	□	□ Bones/ Huesos
			□	□	□ Respiratory System/ Sistema respiratorio

ILLNESSES / ENFERMEDADES

Alguna vez a sido diagnosticado el nino con alguna de las siguientes condiciones?
Has the child ever been diagnosed as having any of the following conditions?

Si **Yes**	No **No**	? **Unknown**	Si **Yes**	No **No**	? **Unknown**	Si **Yes**	No **No**	? **Unknown**
□	□	□ Scarlet fever/ fiebre escarlatina	□	□	□ Polio	□	□	□ Autism/Autismo
□	□	□ Measles/sarampion	□	□	□ Tetanus/Tatano	□	□	□ Diabetes/Diabetes
□	□	□ Chicken Pox/ Varicela	□	□	□ Allergy/Alergia	□	□	□ Anemia/ Anemia
□	□	□ Diptheria/Difteria	□	□	□ Asthma/Asma	□	□	□ Jaundice/Ictericia
□	□	□ Whooping Cough/Tosferina	□	□	□ Convulsions/ convulciones	□	□	□ HIV/Aids
□	□	□ Pneumonia/Neumonia	□	□	□ Fainting/Desmayos	□	□	□ Others/ Otros:_____
□	□	□ Rheumatic Fever/ Fiebre rheumatica	□	□	□ Hepatitis/Hepatitis			_____
□	□	□ Mental retardation/Retraso mental	□	□	□ Mumps/Paperas			_____
□	□	□ Cerebral palsy/Paralisis cerebral						
□	□	□ Emotional disturbance/ Disturbios emocionales						

MEDICATION / MEDICAMENTOS

Ha tenido el Nino alguna reaccion inusual a lo siguiente?
Has the child had any unusual reactions to the following?

Si **Yes**	No **No**	? **Unknown**
□	□	□ Allergy to Latex/ Rubber
□	□	□ Local anesthetic (Novocain)/anestecia local novocaina
□	□	□ Penicillan/ penicilina
□	□	□ Other medicine or foods, explain/otro medicinas o alimentos explique:_____
□	□	□ Phen-Fen/Redux

Does your child have any special problems not listed above? □**Yes** □**No** If yes, please explain:_____

Firma Fecha
Signature_____ **Date**_____

Relacion con el nino Es usted legal mente responsible por el nino
Relationship to child_____ **Are you legally responsible for the child?**_____

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Dear Parents and Guardians,

We would like to welcome you and your children to our dental practice. In order for your child to receive the best possible dental care with a pleasant office experience, we have established after many years of experience in this field the following office policies:

Parents or guardians are welcome to accompany their children into the operatory room during examination and cleaning procedures. We request that during the taking of x-rays on your child that you step outside of the room and upon completion of x-rays you are welcome to return.

Parents or guardians are also welcome to accompany their children into the operatory room during dental treatment as long as the child cooperates with the dentist while the parent is present. We use nitrous oxide gas to relax children if necessary to assist the dentist in completing dental treatment. We have also worked out a system of hand signals from your child to the dentist to let him know when the child is experiencing any discomfort. Most children cooperate with the dentist while their parents are in the room, but should your child become upset or difficult to control we ask that you step out of the room in order for the dentist to regain your child's trust and complete your child's treatment. We have found that some children cooperate better with the dentist if they are not trying to win sympathy from their parents in the room. If the dentist feels that your child is too upset, rather than trying to force dental treatment, our dentist may suggest general anesthesia. The dentist may also feel that it would be better for your child to be referred out for hospital dentistry where your child can be sedated under general anesthesia to complete dental treatment.

Dr. Baker has been a very successful pediatric dentist for almost twenty years with an endless list of satisfied patients. Our entire staffs are professionals who strive to do their very best at all times. Our primary goal in treating any child is to put their health and safety first and foremost during any dental treatment. Thank you for choosing our office.

Dr. Bruce B. Baker & Staff.

Patient Name: _____
Parent/Guardian Signature: _____ Date: _____

.....

Estimados Padres y Tutores,

Bienvenidos a nuestra oficina dental. Para asegurar que su hijo reciba el major tratamiento dental posible y hacerlo una experencia agradable, nos hemos establecido despues de años de experiencia an esta profesion el siguiente reglamento.

Padres o tutores son bienvenidos para acompañar a su hijo al cuarto durante el proceso de examen y limpieza. Les pedimos que durante la toma de radiografias se mantengan afuera del cuarto. Una vez terminado las radiografias, podra regresar al cuarto.

De igual manera, padres o tutores son bienvenidos para acompañar a su hijo al cuarto operatorio durante el tratamiento dental mientras su hijo coopere con el dentista y usted este presente. Oxido nitroso es usado para relajar a ninos solo en casos necesarios, para asistir al dentista en terminar el tratamiento. Tambien les manifestamos a sus ninos si sienten algun dolor durante el procedimiento dental, avisarnos haceiendo senales de mano. Por lo general, la mayoria de ninos son cooperativos con el dentista mientras el padre esta presente en el cuarto, mas si su hijo se vuelve un paciente dificil de manejar, se la pedira que se salga del cuarto para que el dentista pueda obtener la atencion y confianza del nino. Hemos descubierto que algunos ninos cooperan major si los padres no estan presente en el cuarto para que asi no se consienta el llanto del nino. Si el dentista considera que el nino es dificil de manejar y no coopera, en lugar de forsarlo para asi hacer el tratamiento dental, el dentista sugerira el uso de una soulcion oral para sedar y de igual forma relajar a su hijo. En caso debido, el dentista tal vez sugerira que seria major referir a su hijo al hospital, donde se le terminara el tratamiento dental bajo anesthesia general.

Dr. Baker se ha establecido como un dentista pediatrico muy excitoso por caso veinte anos, con una lista interminable de pacientes satisfechos y complacidos. Todo nuestro personal es altamente profesional y todo el tiempo tratan de poner lo major de ellos. Nuestra meta principal al tartar cualquier nino como paciente es cuidar de la salud y seguridad de ellos durante cualquier procedimiento dental. Gracias por escojer nuestra oficina.

Dr. Bruce B. Baker Y Personal.

Nombre de paciente: _____
Aprobacion del padre o tutor: _____ Fecha: _____

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Insurance Payment Release Form

Patient Name: _____

Subscriber Name: _____

Subscriber ID: _____

Insurance Company: _____

I, _____, hereby authorize and direct payment of the 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, I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or 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 activities in connection with this claim.

_____ _____

Print Name **Date**

_____

Signature

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Dear Parents,

We would like to welcome you and your children to our dental office. We gladly accept most insurance policies, however due to a change in our policy, our office is currently collecting patients co-pays based on our usual and customary fees.

After a claim has been submitted to insurance and received by our claims department, if an overcharge has occurred we will gladly compensate the difference of amount. We appreciate your understanding and full cooperation regarding this matter.

Patient Name:_____

Date:_____

Guardian's Signature:_____

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Cancelation Policy

We take great pride in seeing everyone with an appointment in a timely manner. We believe that your time is as valuable as our own.

If you are unable to keep your appointment, please give 24 hour notice so that someone else needing our services may be seen at that time. We will be happy to re-schedule your appointment for a future date at the time.

I understand that failure to cancel or re-schedule an appointment without a 24 hour notice will result in a broken appointment charge of **$25.00**.

Parent/Guardian Signature:_____ Date:_____

Kid's Dental Care

Bruce B. Baker, D.M.D. — **Pediatric Dentistry**

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RESPONSIBILITY AND CONSENT STATEMENT

Date_____

I hereby authorize and request the performance of dental services for myself or for:

Patient Name:_____ Age:_____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for the diagnostic purposes or dental treatment.

I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

Parent or Guardian Signature: _____Date:_____
Relationship to other named: _____

.....

Yo _____Requiero y autorizo el proceddimiento de servicio dental en mi o para:

Nombre de paciente:_____ Anos:_____

Doy mi consentimiento para cualquier procedimiento dental, medicamento o anestesico que tenga que ser administrado por el dentista o su personal supervisado para los propositos de diagnostico o tratamiento dental.

Etiendo que soy responsable por el pago de los servicios proveidos a mi mismo o a la persona que aparece aqui. Independientemente de lo que mu aseguranza (seguro) cubra.

Firma de la persona responsible: _____Fecha:_____
Parentesco con la persona: _____

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INFORMED CONSENT FORM FOR DENTAL TREATMENT

FILLINGS

Benefits:

- Eliminates decay.
- To relieve pain.
- Fill in a whole or space in a tooth.
- Cover eroded areas.
- Protect a sensitive surface.

Possible Complications:

- Tooth may abscess from the filling.
- May fracture tooth.
- Tooth may be sensitive to temperature changes.
- Toxicity from the silver filling is alleged by some.
- Fillings may fall out.

Consequences of not having or postponing treatment:

- Tooth may become unsalvageable.
- Tooth may fracture.
- Decay will get increase.
- Pain will get worse.
- May result in need for a root canal.

Alternatives:

- Temporary filling.
- Extraction

EXTRACTIONS

Benefits:

- Last resort for an unsalvageable tooth.
- Eliminate pain.
- Remove teeth that are out of position.
- Eliminate infection.

Possible Complications:

- Fractures particles may remain.
- Irritation to nerves may cause temporary or
- permanent numbness.
- Part or the entire tooth may be lodged in the sinuses, requiring more surgery.
- Bad infections may take a longer time to clean up.
- Jaw may be stiff and difficult to open for some time.
- If the jaw bone is weak it can fracture.

Consequences of not having or postponing treatment:

- Spread of infection.
- Swelling.
- Pain.
- Fever.

Alternatives:

- None.

X-RAYS

Benefits:

- To obtain a complete diagnosis.
- Find hidden problems.
- X-rays are taken by qualified personnel.
- Help determine treatment options.

Possible Complications:

- Exposure to minimal x-ray radiation.
- X-ray pictures remain the property of the dental of

Consequences of not having or postponing treatment:

- Can not perform dental services.

Alternatives:

- None.

CLEANING/SCALING

Benefits:

- Clean mouth.
- Eliminates odor.
- Prevents gum disease.
- Some portions may be performed by auxiliary pers

Possible Complications:

- Sensitivity.
- Sensitive gums.
- Filling may be loosened (this is normal if the fillin ready to fall out).

Consequences of not having or postponing treatment:

- Stains on teeth.
- Odors.
- Gum disease.
- Premature loss of teeth.

Alternatives:

- None.

BONDED FACING

Benefits:

- Aesthetics- Teeth look nicer.
- Cover crooked teeth.
- Close spaces and gaps.
- Cover discolored teeth.

Possible Complications:

- Edges can stain after time and need periodic maintenance.
- Breakage can occur resulting in the need to be fixe
- Difficult to remove.

Consequences of not having or postponing treatment:

- None other than appearance.

Alternatives:

- None.

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INFORMED CONSENT FORM FOR DENTAL TREATMENT

continued

LOCAL ANESTHETICS

Benefits:

- Avoid pain or discomfort during treatment.

Possible Complications:

- Prolonged numbness.
- Nerve damage.
- Bruising.
- Rare circumstances include all those applicable to
- general reactions up to and including death.

Consequences of not having or postponing treatment:

- Possible mild to severe pain during and after treatment.

Alternatives:

- Willingness to endure possible mild to severe pain during treatment.

CROWNS (CAPS)

Benefits:

- Aesthetics
- To repair a tooth that is broken.
- To prevent a tooth from fracture.
- To eliminate a space where food is being trapped.
- To hold a false tooth in place as a part of a bridge.
- To make a solid structure to attach a partial dentur
- To splint loose teeth together to strengthen them.
- If the tooth can not be filled.

Possible Complications:

- Porcelain portion of crown may fracture.
- Crown may come off and need to be re-cemented.
- Tooth may abscess and require further treatment.
- Future decay may require a new crown.

Consequences of not having or postponing treatment:

- Possibility of the tooth fracturing.
- Tooth may need to be extracted.
- Tooth may need a root canal in addition to the cro
- May need bridge work or dentures.

Alternatives:

- Extraction.
- Temporary crown.
- Stainless Steel crown.

I have read the above statements and have received a copy of them. I recognize the importance of these statements in helping me make decisions regarding my child's dental needs. I recognize that failure can occur for various reasons and complications can occur in any procedure. I also understand that where decay was present, where a tooth was fractured or abscess these problems could still affect the tooth even after the tooth has been restored. In order to receive treatment I contract that if there is any indifference or disagreement between my attending dentist and myself I will first present such indifference or disagreement to my attending dentist in order to resolve the issue. If the attending dentist and I are unable to reach an agreement then I agree to take the problem to a reconciliation board, such as the Dental Society or California State Consumer Affairs Board of Dental Examiners. I agree to accept their resolution in lieu of pursuing remedies by way of litigation in consideration of helping keep the costs of treatment and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members.

Name of Patient:_____

Name of guardian:_____

Signature:_____ **Date:**_____

Kid's Dental Care
42210-100 Lyndie Lane
Temecula, CA 92591

Guardian Information

Patient's Name: _____

Guardian's Name: _____

Guardian's D.O.B.: _____ Guardian's SSN: _____

Guardian's Current Address: _____
_____
_____
NO P.O. BOX, PLEASE

Guardian's Telephone #: Home: _____ Cell: _____
Work: _____

Guardian's relationship to the child: ( ) Mother ( ) Father
( ) Other: _____

Guardian's Signature: _____ Date: _____

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

* Request Appointments Online
* Confirm Appointments via Email
* Receive Text Message Appointment Reminders
* Submit Patient Satisfaction Surveys
* Refer Your Friends Online

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email or by replying to a text message with 'STOP'. Standard Text Messageing rates apply.

PLEASE VERIFY YOUR CONTACT INFORMATION

* Cell Phone: _____

_____ Check here to Opt In to Text Messages

* Email: _____

_____ Check here to Opt In to Email

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Kids Dental Care-Temecula in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of you PHI. Your PHI may be disclosed to an affiliate that performs service for Kids Dental Care-Temecula in the administration of your benefits. Our affiliates do not sell, share, or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

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

_____

Signature Date

Establishment of Financial Responsibility:

Bruce B. Baker, DMD. 42210 Lyndie Lane. #100.
Temecula California, 92591. (951)506-1666

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:_____

Kid's Dental Care

42210Lyndie Lane, Suite 100
Temecula, CA 92591
T: 951-506-1666/F: 858-670-8580
Email: poway4kidsdentalcare@yahoo.com

Consent form for the use of Photographs or Videos

"Kid's Dental Care, Bruce B. Baker, DMD, recognizes the need to ensure the welfare and safety of all young people in dental offices."

In accordance with our child protection policy we will not permit photographs, video or other images of young people to be taken without consent of the parents/carers and children.

- For Consideration herein acknowledged as received, and by signing this release I hereby give the Photographer / Filmmaker and Assigns my permission to license the Content and to use the Content in any Media for any purpose (except pornographic or defamatory) which may include, among others, advertising, promotion, marketing and packaging for any product or service.
- I agree that this release is irrevocable, worldwide and perpetual, and will be governed by the laws (excluding the law of conflicts) of the country/state that is nearest to the address of ---the Model (or Parent*).
- It is agreed that my personal information will not be made publicly available but may only be used directly in relation to the licensing of the Content where necessary and may be retained as long as necessary to fulfill this purpose, including by being shared with sub-licensees / assignees of the Photographer / Filmmaker and transferred to countries with differing data protection and privacy laws where it may be stored, accessed and used.

Kid's Dental Care, Bruce B. Baker, DMD, will take all steps to ensure these images are used solely for the purposes they are intended. If you become aware that these images are being used inappropriately you should inform Kid's Dental Care, Bruce B. Baker, DMD, immediately.

Child Information (If more than on child, just add info on the right hand side.
Name (print) _____
Date of Birth (DD/MM/YEAR) _____
Gender: male female / male female / male female

I,_____,consent to Kid's Dental Care, Bruce B.Baker, DMD, to Photographing and videoing my child/children,_____.

_____ _____ _____
Parent/Guardian Signature Date Parent/Guardian Email

- **Witness** (NOTE: All persons signing and witnessing must be of legal age and capacity in the area in which this Release is signed. A person cannot witness their own release)

Name (print) _____
Signature _____
Date _____

Dr. Bruce B. Baker, DDS
42210 Lyndie Lane #100 ◆ Temecula, CA 92591 ◆ (951)506-1666

Kids Dental Care

Thank you for choosing us as your child's dental health care provider. We know you had a world of options and we are committed to providing your family with the highest quality of health care, and personably accommodate for all you customer service needs. We value you and your feedback! Please fill out this short survey so we know how your experience was today.

Overall, how would you rate your child's visit to our office?

- ☐ Very positive
- ☐ Somewhat positive
- ☐ Undecided/ N/A
- ☐ Somewhat negative
- ☐ Very Negative

How satisfied are you with the level of attention given to your child?

- ☐ Very satisfied
- ☐ Quite satisfied
- ☐ Somewhat satisfied
- ☐ Somewhat dissatisfied
- ☐ Quite Dissatisfied

Comments: _____

_____

_____

_____

Name:_____ Email:_____

Give us your email to be included in raffles, contests, fun events and promotional offers!
No spam, no chain mail.