Kristin Newsom D.D.S, M.S.

Child's full legal name_____Age_____Birthdate_____ Sex F M
Name child goes by_____
Child's Mailing Address_____
City_____State_____Zip_____Home Phone# _____
Child's Social Security # _____School_____Grade_____
Name & age of siblings _____
Home E-mail Address_____
Emergency Contact Name_____ Phone Number_____
How did you hear about our office?_____
Who is your family dentist?_____
Do parents live together? ___Yes ___ No If not, with whom does the child live? _____

Relationship to Child: _____
Relationship Status: Single Married Separated Divorced Widowed Partner
Name_____DOB_____Cell Phone #_____
Address (if different from child) _____
City_____State_____Zip_____
Employer_____Occupation_____
S.S. #_____Driver's License #_____Work #_____
Insurance Company Name: _____ ID #_____Group # _____
Insurance Co Address: _____Phone #_____

Relationship to Child: _____
Relationship Status: Single Married Separated Divorced Widowed Partner
Name _____DOB_____ Cell Phone #_____
Address (if different from child) _____
City_____State_____Zip_____
Employer_____Occupation_____
S.S. #_____ Driver's License #_____Work #_____
Insurance Company Name: _____ ID #_____Group # _____
Insurance Co Address: _____Phone #_____

Our office communicates with our patients electronically, via e-mail and text messaging. Please inform us of your preference of communication:

____E-mail E-mail_____
____Text Cell #_____
____Please do not contact me by e-mail
____Please do not contact me by text

METHOD OF PAYMENT * Fees for dental services are due at time of treatment*
_____Check, cash, or credit/debit card
_____Dental Insurance - Plus co-payment (At the present time we are only participating providers with **Humana, Cigna, Aetna, Aetna DMO, Liberty, Guardian** and **Premier Providers** with **Delta Dental of CA.** As a courtesy, our office will file for insurance benefits for treatment rendered. Any deductibles, co-payments, or balances not covered by your insurance must be paid in full at treatment visit.
All account balances which have not been paid within 30 days by your insurance company become the responsibility of the parent/guardian.

***Returned Check Fee- $30.00** ***Missed Appointment Fee-$25.00** ***After Hours Call $25.00**

CHILD'S MEDICAL HISTORY

Child's full name_____Birthdate_____
Name of child's pediatrician or physician_____
Has your child been hospitalized since birth? ___Yes ___No if yes, explain_____
_____
Is your child allergic to any medications or foods? ___Yes ___No if yes, explain_____
Is your child presently taking any medication? ____Yes ____No if yes, explain_____
Please check any of the following medical conditions your child has experienced:

___Asthma ____Inhaler	___ Special Needs	___ Convulsions/Epilepsy
___ Anemia	___ Heart Condition	___ HIV/AIDS
___ Hepatitis	___ Lung Disease	___ Ear Problems
___ Abnormal Bleeding	___ Nose/Throat Disorder	___ Tubes in Ears
___ Blood Disease	___ Tonsils/Adenoids Removed	___ Speech/Vision Problems
___ Diabetes	___ Cancer/Tumors	___ ADD/ADHD
___ Tuberculosis	___ Stomach/Kidney Problems	___ Emotional Disorder
___ Skin Disorder	___ Liver Problems	___ Latex Allergy
___ Autism / Asperger's Syndrome	___ Seasonal Allergies	___ Other_____

Please explain any medical condition(s) or concerns that your child has_____
_____

CHILD'S DENTAL HISTORY

1. Is your child on a bottle? ____Yes ____No if no, at what age was it discontinued? _____
2. Is your child a thumb/finger sucker or ever used a pacifier? ____Yes ____No Age discontinued? _____
3. Is your primary source of water from a well? ___Yes ___No
4. Has your child ever been seen by a dentist? ____Yes ___No
5. If so, please give the date of last dental care: _____Previous Dentist Name:_____
6. Has your child had problems with previous dental treatment? ___Yes ___No
7. If yes, please explain:_____
8. Has your child had any type of injury to his/her teeth? ___Yes ___No
9. If yes, please explain:_____
10. Is your child in pain today? ___Yes ___No if yes, please explain: _____
12. Does your child have a dental condition about which you are especially concerned? ___Yes ___No
13. If yes, please explain: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize the office to contact my cell phone regarding treatment and/or billing. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parent/Guardian_____Date_____

Pure Pediatric Dentistry-Patient Information Sheet

Thank you for choosing us as your dental care provider. Our goal is to provide the best dental service available to you, and your family. The following information is our office policies which are required to be read/signed prior to any treatment in our office:

- Contact Information- We request that you update us with any changes to your personal information i.e. phone numbers, address, insurance information, etc.
- Payment for Services- Payment is required at the time of service. We accept cash, check, Visa, MasterCard debit/credit cards, as well as Care Credit.
- Treatment Plans- All financial arrangements are necessary prior to treatment scheduling. Please ask us to go over any treatment that you want more information on. We do realize that dental terminology can be difficult to understand. We are here to make sure that you and your children feel comfortable with all aspects of your dental experience, including actual treatment and financial arrangements.
- Account Responsibility- As a courtesy to you, we are happy to bill any validated insurance plan. **If your insurance has not paid within 45 days, the balance will be billed to you directly.** The balance of your account is always your responsibility whether your insurance company pays or not.
- Insurance Billing- We request that you carefully read through your dental insurance policy so you are aware of any deductibles, limitations, and exclusions. Some of our services may not be covered under your insurance plan; this means you will be responsible for those fees. **All quotes for coverage are only estimates, not a guarantee of your insurance company's payment.** We cannot guarantee payments due to factors like eligibility, outstanding claims, etc. which can affect the amount of remaining benefits available.
- Usual and Customary Fees- Our fees are based on what is usual and customary in our area for a specialist. We are considered "in network" with certain dental insurance companies, please check with us for a current list.
- Returned Checks- The charge for a NSF check will be $25.00. You must pay in full for the NSF check and NSF fee within 10 days of notice. If the payment is not received by the due date, we will forward the returned check to the District Attorney's office. If we choose to continue care of your family, you will be expected to pay in full at the time of service with cash or credit card.
- Collection Accounts- When your account remains unpaid after 90 days, we maintain the right to refer the account to an outside collection agency. You may be asked to find another provider.
- Appointments- We expect you to accompany your child to our office for all appointments. All other arrangements must be made in advance with our front office staff. We request that you remain in the waiting room during treatment and sedation appointments. The doctor and assistant need to have adequate room to perform treatment and monitor your child during the procedures. If you would like to see your child, our front office staff is always happy to accompany you to the treatment rooms to check in during the procedure.
- Guarantor- The parent who brings in the child initially and signs the paperwork is responsible for the payments to our office. We do not bill former spouses.
- Late arrivals, cancellations, and no shows- Please be considerate to our office as we set aside specific time for your child's appointment. We require 48 hours' notice to cancel or reschedule an appointment. Failure to give proper notice will result in charges to your account. $25.00 fee for the first missed hygiene appointment, and a $50.00 for the second. $50.00 charge for a missed restorative appointment and a $100.00 charge for the second. If a third missed appointment occurs, you may be asked to find another provider.
- After hours availability- Our answering service is available after hours for emergencies, if utilized a $25.00 fee is incurred. Insurance does not cover this service.
- Copies of medical records, x-rays, and other forms- Records requests are generally fulfilled within 5 days. If the request is immediate, a fee may apply.

I acknowledge and understand the office policies explained above and have received a copy. I hereby authorize my insurance company to pay Kristin L. Newsom, DDS, MS directly. A copy of this authorization can be considered an original for insurance purposes. My signature on this document indicates I have read, understand, and agree to the policies outlined in this document.

Signature

Date

_____

_____

Print Name

Relationship to Child(ren)

Child(ren)s name(s) and date(s) of birth

Patient Acknowledgement of the Receipt of the

Notice of Privacy Practices

I have received (or have been offered) a copy of this office's Notice of Privacy Practices. By signing this form, you are giving this office your consent to disclose health information about you for treatment, payment, health care operation purposes.

Signature: _____ **Date:** _____

Patient Name: _____

Patient representative (if minor): _____

Witness: _____

Patient Records Release

In the event that our office may need to forward a patients x-rays or records to another facility to coordinate care, we ask that you sign a records release form in advance to avoid a delay in our ability to transfer the records in a timely manner.

Patient:_____ _____ **Date:**_____

First Name Last Name

Patient or Guardian Signature:_____

Relationship:_____

For Office Use Only

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

- ○ Individual refused to sign
- ○ Communications barriers prohibited obtaining the acknowledgements
- ○ An emergency situation prevented us from obtaining acknowledgments
- ○ Other {please Specify}_____

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