Today's Date _____

Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____
Nickname _____ Sex _____
Birthdate _____ Age _____
SS #/SIN _____
School _____ Grade _____
Child's Home Address _____
City _____ State/ Prov. _____ Zip/ P.C. _____
Phone _____

Responsible Party

Name _____
Relationship _____
Address _____
City _____ State/ Prov. _____ Zip/ P.C. _____
E-Mail _____
SS #/SIN _____
DL # _____

Who is responsible for making appointments?

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Best time to call _____
Time _____ Days _____
Whom may we thank for referring you? _____

Mother ☐ Stepmother ☐ Guardian D.O.B _____

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS #/SIN _____
DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian D.O.B _____

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. _____
Email _____
Employer _____
Occupation _____
SS #/SIN _____
DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

IN CASE OF EMERGENCY CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

Primary Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS #/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/ Prov. _____ Zip/ P.C. _____

Additional Insurance

Insured's Name _____
Relationship _____
Birthdate _____ SS #/SIN _____
Employer _____ Date Employed _____
Occupation _____
Insurance Company _____
Group # _____ Employee # _____
Ins. Co. address _____
City _____ State/ Prov. _____ Zip/ P.C. _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.
Payment in full at each appointment. ☐ Cash ☐ Personal Check
Credit Card ☐ Visa ☐ MC ☐ I wish to discuss the office's payment policy.

MEDICAL

Has your child had any of the following medical problems? *Circle yes (Y) or No (N)*

Allergies to drugs or foods	Y N	Ear infections	Y N	HIV+ /AIDS	Y N
Asthma or lung problems	Y N	Handicaps or disabilities	Y N	Hospital stays or operations	Y N
Blood transfusions	Y N	Heart defect (congenital)	Y N	Learning disabilities	Y N
Cancer	Y N	Heart murmur	Y N	Rheumatic Fever	Y N
Convulsions or epilepsy	Y N	Hemophilia or abnormal bleeding	Y N	Trauma to mouth or face	Y N
Developmental delay	Y N	Hepatitis	Y N	Tuberculosis (TB)	Y N
Diabetes	Y N	High fevers	Y N	Cerebral Palsy	Y N
				Attention Deficit Disorder	Y N

Other medical problems: _____

Please discuss problems further, if necessary: _____

_____

_____

Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? Y N

Is your child currently taking any medications? Y N What kind? _____

Is your child taking any supplemental fluoride? Y N If yes, how? Tablets, drops, water, vitamins (please circle)

Does your child have any breathing problems? Y N Breathes primarily through nose or mouth? (please circle)

Does your child snore? Y N

HABITS

Does your child have or had any of the following habits?

Thumb or finger sucking	Y N	Pacifier use	Y N	Nail biting	Y N
Lip sucking or biting	Y N	Biting hard objects	Y N	Tooth grinding	Y N

Did your child use a bottle? Y N If yes, when did he/she stop? _____

Does your child currently use a bottle? Y N If yes, how often during the day? _____

Is the bottle used at night? Y N What do you put in the bottle? _____

Does your child currently nurse? Y N

FAMILY DENTAL HISTORY *(Circle appropriate parent, if yes)*

Has Mother or Father had a lot of decay? Has Mother or Father had orthodontic care?

Does Mother or Father have periodontal disease? Does Mother or Father have TMJ problems?

CHILD'S DENTAL HISTORY

Has your child seen a pediatric dentist before? Y N

If yes, the approximate month and year of last visit: _____ Where? _____

Has your child had any unfavorable experiences in a dental or medical office? Y N

Does your child have any dental problems presently? Y N

If yes, please explain: _____

How often does your child brush his/her teeth per day? _____ Do you help? Y N

How often does your child floss? _____ Do you floss your child's teeth? Y N

How do you think your child will act toward the dentist? _____

Purpose of today's dental visit? _____

_____ Examining Doctor's Initials _____ Date _____

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 and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date

LARRY J. DIAMOND, D.D.S.
General Dentistry for Children and Adults
3551 Florista Street, Suite 2A, Los Alamitos, CA 90720
(562) 430-1013 (714) 828-5951

OUR FINANCIAL POLICY

Payment for professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan which fits your timetable and budget, and gives you/and or your child the best possible care. Our office accepts cash, check, debit cards, and credit cards (Mastercard, Visa, Discover Card, and American Express). We also offer extended payment plans through Care Credit, an outside finance company (GE Money Bank).

FOR PATIENTS WITHOUT DENTAL INSURANCE:

Non-insured patients are expected to pay in full the day service is rendered by one of the methods listed above unless specific arrangements are made in advance with our treatment coordinator.

FOR PATIENTS WHO HAVE DENTAL INSURANCE:

1. You must provide all necessary dental insurance billing information and have coverage that allows you complete freedom of choice in selecting your dentist. (We do not participate in any Dental Maintenance Organizations.)
2. Our office accepts "assignment of benefits". This means that you must sign the portion of your insurance form that "assigns payment" directly to our office. (There are a limited number of insurance companies that do not honor the assignment of benefits. When this happens, you will be responsible for payment in full since the insurance company pays you directly.) *By law, your insurance company is required to pay each claim within 30 days of receipt.*
3. Dental insurance is meant to be an aid in receiving dental care. *No insurance pays 100% of all procedures.* The percentage paid is usually determined by how much you or your employer has paid for coverage or the type of contract your employer has purchased from the insurance company. Many patients think that their insurance pays 90%-100% of all dental fees. This is not true! Most plans only pay between 50%-80% of the average total fee. Additionally, most insurances require a deductible be paid by you one time each year per patient.
4. Many insurance companies require prior authorization of dental work in excess of a certain dollar amount before treatment can begin. If you choose to begin treatment without this predetermination of benefits/authorization, you may be responsible for the entire treatment fee. A minimum down payment of 50% of the fee will be required.

Please understand that the ultimate responsibility for payment of dental work is yours. Insurance is a third party and is not directly responsible for payment to our office. We are happy to assist you in understanding the particulars of your insurance plan. Please keep our office informed of any insurance changes such as insurance company name, address, policy number or change of employment. *Always feel free to ask any questions concerning your payments, insurance or dental treatment.* We are here to help you and to provide the highest quality in dental care.

I have read and understand the financial policies as described above.

X_____ Date:_____
(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY)