Leslie J. Butler DDS, MSD
801 E. Chapman Avenue, Suite 226, Fullerton, CA 92831

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #:(____) _____ Social Security #: _____

Child's Name: _____ Child's Birthdate: ____ /____ / ____ Child's Age: _____
Last **First** **MI**

Nickname: _____ ☐ Male ☐ Female School: _____ Grade: _____

Child's Home Address: _____

Who may we thank for referring you? _____

What is the primary reason for today's visit? _____

Is your child adopted? ☐ Yes ☐ No Has any member of your family been or is currently a patient in this office? ☐ Yes ☐ No

If yes, name: _____

Dental History

Is your child currently in pain? ☐ Yes ☐ No
Is this your child's first time seeing a dentist? ☐ Yes ☐ No
Has your child experienced problems with previous dental work? ☐ Yes ☐ No If yes, explain: _____

Previous Dentist: _____ Date of Last Visit: _____ Date of Last X-Ray: _____

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Have there been any injuries to your child's teeth, jaws, falls, blows, chips, etc. ☐ Yes ☐ No
Does your child take fluoride supplements? ☐ Yes ☐ No
Has your child been seen by an orthodontist? ☐ Yes ☐ No Who? _____
Does your child brush his/her teeth daily? ☐ Yes ☐ No Does he/she require parental help? ☐ Yes ☐ No
Does your child floss his/her teeth daily? ☐ Yes ☐ No Does he/she require parental help? ☐ Yes ☐ No

Name of Parent's dentist: _____

Does/Did your child have any of the following habits? (please check)

☐ Lip sucking and Nail Biting ☐ Clenching/Grinding Teeth ☐ Tongue/Cheek Biting ☐ Mouth Breather
☐ Chewing on Objects ☐ Thumb/Finger Sucking ☐ Used Pacifier ☐ Speech Problems
☐ TMJ/TMD Pain ☐ Nursing Bottle Habits ☐ Tongue Thrust ☐ Breast Fed

Medical History

Child's Physician: _____ Phone: (___) _____ Date of last visit: _____

Address: _____

Is your child under the care of a physician? ☐ Yes ☐ No Please explain: _____

Does your child have social/personality/temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are Immunizations Current?** ☐ Yes ☐ No

Please list all medications and dosage that your child is currently taking: _____

Please list all drugs and/or things that cause your child allergic reactions: _____

Anything you would like to discuss with the Doctor in Private? ☐ Yes ☐ No

Has your child had/experienced any of the following: (please check)

Abnormal Bleeding	☐ Y ☐ N	Chicken Pox	☐ Y ☐ N	Heart Murmur	☐ Y ☐ N	Mononucleosis	☐ Y ☐ N
AIDS/HIV	☐ Y ☐ N	Congenital Birth Defect	☐ Y ☐ N	Hemophilia	☐ Y ☐ N	Recurrent/Frequent Headaches	☐ Y ☐ N
Allergies	☐ Y ☐ N	Congenital Heart Defect	☐ Y ☐ N	Hepatitis	☐ Y ☐ N	Rheumatic	☐ Y ☐ N
Anemia	☐ Y ☐ N	Diabetes	☐ Y ☐ N	High Blood Pressure	☐ Y ☐ N	Seizures	☐ Y ☐ N
Any Hospital Stays	☐ Y ☐ N	Endocrine System Disorders	☐ Y ☐ N	Hives	☐ Y ☐ N	Scarlet Fever	☐ Y ☐ N
Any Operations	☐ Y ☐ N	Epilepsy	☐ Y ☐ N	Kidney Problems	☐ Y ☐ N	Sickle Cell Anemia	☐ Y ☐ N
Asthma	☐ Y ☐ N	Frequent Infections	☐ Y ☐ N	Liver/GI System Problems	☐ Y ☐ N	Sight Disorders	☐ Y ☐ N
Blood Dyscrasia	☐ Y ☐ N	Handicaps	☐ Y ☐ N	Low Blood Pressure	☐ Y ☐ N	Significant Injuries	☐ Y ☐ N
Blood Transfusion	☐ Y ☐ N	Behavior/Learning Disabilities	☐ Y ☐ N	Lupus	☐ Y ☐ N	Skin Rash	☐ Y ☐ N
Breathing/Lung Problems	☐ Y ☐ N	Mentally/Physically Disabled	☐ Y ☐ N	Measles	☐ Y ☐ N	Tonsillitis	☐ Y ☐ N
Cancer/Tumors	☐ Y ☐ N	Hearing Impaired	☐ Y ☐ N	Mitral Valve Prolapse	☐ Y ☐ N	Tuberculosis (TB)	☐ Y ☐ N

Please discuss any serious medical problems your child experiences(ed): _____

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Parents Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single Family E Mail: _____

Father/Step Birthdate: ____/____/____ Home #: (___) _____ Work #: (___) _____

Name: _____ Social Security #: _____ Drivers License #: _____

Employer: _____ Occupation: _____

Cell #: _____

Mother/Step Birthdate: ____/____/____ Home #: (___) _____ Work #: (___) _____

Name: _____ Social Security #: _____ Drivers License #: _____

Employer: _____ Occupation: _____

Cell #: _____

Name of parent who resides with the child: _____

Nearest relative: _____ Address: _____ Phone: _____

Is your child covered by a dental insurance plan? ☐ Y ☐ N

Insurance Information

Primary Insurance: Is insurance provided through an employer? ☐ Y ☐ N If so please list: _____

Insurance Co. Name: _____ Phone #: (____) _____

Subscriber#: _____ Group #: _____

Insurance Co. Address: _____

Insured's Name: _____

Secondary Insurance: Is insurance provided through an employer? ☐ Y ☐ N If so please list: _____

Insurance Co. Name: _____ Phone #: (____) _____

Subscriber#: _____ Group #: _____

Insurance Co. Address: _____

Insured's Name: _____

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to Leslie Butler, DDS, Inc. insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

_____
Signature Date

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and 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 authorize the Leslie Butler, DDS, Inc. to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and/or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

_____
Signature Date

Medical History Review: _____
Signature Date

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TO OUR PATIENTS AND FAMILIES

Thank you for choosing Butler Pediatric Dentistry for your child's dental care. We consider families to be an essential participant in your child's care and wish to support and respect your needs while your child is under our care. We want you to understand your rights and responsibilities as families and patients at Butler Pediatric Dentistry. Your signature on this form provides consent for treatment and payment, and acknowledges receipt of other general information. If you have questions, please ask your provider.

Consent for Treatment
I hereby authorize and request the performance of dental service for my minor child. I understand that at the first appointment (examination, necessary x-rays, cleaning, topical fluoride) the doctor will explain my child's treatment needs and the various behavior management approaches. At this appointment the doctor's staff will review any associated fees. I also realize that any restorative treatment will be accomplished at a later date.

Missed/Broken Appointment Policy
Due to the limited space in our schedule and the need to provide timely service to all of our patients it is very important that you keep your scheduled appointments. It is understandable that occasionally you may need to reschedule due to an emergency or illness. We ask that you give us the courtesy of a 48 hour notice so that we will have the opportunity to use your appointed time to provide treatment for others in need. If you cancel your appointment without 48 hours notice or if you "No-Show" for your appointment then you will be required to pay a **$50.00 Non-Refundable Fee**. **Initial _____**

Assignment of Benefits (AoB) and Release of information (RoI)
- I consent to and authorize that payment of benefits for healthcare related services be made to Leslie Butler, DDS, Inc. This consent specifically authorizes Butler Pediatric Dentistry to release Protected Health Information (PHI) to insurers, governmental agencies and their agents for billing purposes and determination of benefits.
- I assign any benefits payable for provider services to the provider or organization providing the services
- **I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of Butler Pediatric Dentistry and of providers rendering services not otherwise paid by my health insurance or other payor. All charges due are payable upon receipt of the bill. If a payment is not made within 30 days after receipt of bill, a delinquent charge or interest of 18.00% (1.5% monthly rate) will be added. I agree to pay all costs of collection including attorney fees, collection fees and court costs Initial _____**
- The terms of this AoB and RoI will be enforced until final payments are made for all services.
- If and when there are changes to my insurance plans, I will notify Butler Pediatric Dentistry and sign a new agreement.

Insurance
Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 30 days, the balance may be transferred to your account. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and customary under the terms of your insurance policy. Our practice is committed to providing the best treatment for our patients and we charge what is the usual and customary rates for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of usual and customary rates.

Your complete insurance information must be presented at the time services are provided. Insurance claims cannot be backdated. Most benefits will be verified before your insurance company can be billed.

All insurance co-pays and deductibles must be paid at the time of service.

AT THIS OFFICE WE FOLLOW THE GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY IN REGARD TO FREQUENCY OF X-RAYS, CLEANINGS, FLUORIDE TREATMENTS AND RESTORATIVE CARE. AS SPECIALISTS WE CONSIDER THESE GUIDELINES TO BE THE STANDARD OF CARE (BEST TREATMENT FOR YOUR CHILD). THESE GUIDELINES ARE NOT DICTATED BY DENTAL INSURANCE AND IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHETHER YOUR PARTICULAR INSURANCE PLAN WILL REIMBURSE YOU FOR THESE SERVICES. PLEASE CALL YOUR INSURANCE COMPANY WITH QUESTIONS REGARDING FREQUENCIES.

We would be happy to discuss our charges and how they relate to your particular situation. We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account

_____ _____
Print Patient's Name Date

_____ _____
Signature/Relationship to Patient Print Your Name

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Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accounting Act of 1996 (HIPAA). I understand that this information can an will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____
Print Patient's Name Date

_____ _____
Signature/Relationship to Patient Print Your Name

Media Release

I hereby consent for Butler Pediatric Dentistry to use, reproduce, exhibit or distribute (in full or in part) any photograph, video, film, and/or audio recordings made of my child or his/her likeness; and/or any written extract of such recordings in which he/she may be included, for any purpose whatsoever, in any medium now known or in the future invented.

I hereby release, discharge, and agree to hold harmless Butler Pediatric Dentistry and all persons acting under its permission or authority from any liability or injury that may occur while performing or appearing in the said video, audio, or photographic production.

Parent or Legal Guardian: _____
(Print name)

Signature: _____

Date: _____

Address: _____

City: _____ State: _____ Zip: _____