WELCOME

Tell Us About Your Child

Today's Date: ___/___/_____ **Child's Name**: _____ Nickname: _____
Last First Middle

Child's Birthdate: ___/___/_____ Child's Age: _____ Grade: _____ School: _____

Child's Social Security #: _____

Child's Home Address: _____
Street City State Zip

Whom may we thank for referring you? _____ Other family members seen by us: _____

Parent's Information

Parent's Marital Status: □Married □Divorced □Separated □Widowed □Remarried □Single

Mother: □Stepmother □Guardian Birthdate: ___/___/_____

Home Phone #: (_____)_____ Cell Phone #: (_____)_____ Work Phone #: (_____)_____ Ext: ___

Name: _____ Social Security #: _____ Driver License #: _____

Home Address: _____
Street City State Zip

Employer: _____ How long there? _____ Occupation:_____

Father: □Stepfather □Guardian Birthdate: ___/___/_____

Home Phone #: (_____)_____ Cell Phone #: (_____)_____ Work Phone #: (_____)_____ Ext: ___

Name: _____ Social Security #: _____ Driver License #: _____

Home Address: _____
Street City State Zip

Employer: _____ How long there? _____ Occupation:_____

Person Responsible for Account

Name: _____ Relation: _____

Home Phone #: (_____)_____ Cell Phone #: (_____)_____ Work Phone #: (_____)_____ Ext: ___

Social Security #: _____ Driver License #: _____

Employer: _____

Billing Address: _____
Street City State Zip

Who is responsible for making appointments?

Name: _____

Home Phone #: (_____)_____ Cell Phone #: (_____)_____ Work Phone #: (_____)_____ Ext: ___

Insurance Information

Primary Insurance Dental Coverage? □ Yes □ No Medical Coverage? □ Yes □ No Orthodontic Coverage? □ Yes □ No

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

Group # (Plan, Local, or Policy #): _____ Member ID# _____

Insurance Co. Address: _____
Street City State Zip

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/_____ Insured's Social Security #: _____

Insured's Employer: _____

Employers Address: _____
Street City State Zip

Dental History

Why have you come to the dentist today? _____

Is your child currently in pain? □ Yes □ No

Has your child ever experienced pain/discomfort in his/her jaw joint (TMJ/TMD)? □ Yes □ No

Is your child's water fluoridated? □ Yes □ No

Is your child taking fluoridated supplements? □ Yes □ No

Does your child floss daily? □ Yes □ No

Brush daily? □ Yes □ No

Previous/Present Dentist: _____ Last Visit: ___/___/_____

Why did you leave your previous dentist? _____

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

Does/did the child have any of the following habits?

□ Y □ N Breast Fed	□ Y □ N Mouth Breather	□ Y □ N Thumb/Finger Sucking
□ Y □ N Chewing on Objects	□ Y □ N Nail Biting	□ Y □ N Tongue/Cheek Biting
□ Y □ N Clenching/Grinding Teeth	□ Y □ N Nursing Bottle Habits	□ Y □ N Tongue Thrust
□ Y □ N Lip sucking/Biting	□ Y □ N Speech Problems	□ Y □ N Used Pacifier

Medical History

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

Physician's Address: _____

Street City State Zip

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

Describe your child's current physical health is: □ Good □ Fair □ Poor **Are Immunizations current?** □ Yes □ No

Please list all drugs that the child is currently taking: _____

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

Anything you would like to discuss with the Doctor in private? □ Yes □ No

Has the child had/experienced any of the following?

□ Y □ N Abnormal Bleeding	□ Y □ N Diabetes	□ Y □ N Low Blood Pressure
□ Y □ N HIV/AIDS	□ Y □ N Epilepsy	□ Y □ N Lupus
□ Y □ N Allergies	□ Y □ N Handicaps/Disabilities	□ Y □ N Measles
□ Y □ N Anemia	□ Y □ N Hearing Impairment	□ Y □ N Mitral Valve Prolapse
□ Y □ N Any Hospital Stays/Operations	□ Y □ N Heart Murmur	□ Y □ N Mononucleosis
□ Y □ N Asthma	□ Y □ N Hemophilia	□ Y □ N Rheumatic Fever
□ Y □ N Blood Transfusion	□ Y □ N Hepatitis	□ Y □ N Scarlet Fever
□ Y □ N Cancer	□ Y □ N High Blood Pressure	□ Y □ N Sickle Cell Anemia
□ Y □ N Chicken Pox	□ Y □ N Hives	□ Y □ N Skin Rash
□ Y □ N Congenital Heart Defect	□ Y □ N Kidney Problems	□ Y □ N Tonsillitis
□ Y □ N Convulsions	□ Y □ N Liver Problems	□ Y □ N Tuberculosis

Please discuss any serious medical problems the child experiences/ed: _____

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. My method of payment will be _____.

_____

Signature of parent or guardian Date

The parent or guardian who accompanies the child is responsible for payment at the time of service.

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA. I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. David Kitahara and Dr. Bryan Kitahara all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of parent or guardian Date

David J. Kitahara, D.D.S.
Bryan J. Kitahara, D.D.S.
8339 Cherry Lane
Laurel, MD 20707
301-498-0545

Appointment Policy

We make every effort to see all patients on time and request that you extend the same courtesy to us. Appointment times are reserved exclusively for you and will be scheduled at times best suited for the treatment involved. Any changes in appointments greatly affect other patients.

We require a minimum notice of **48 hours** for any appointment changes. A fee of $88.00 will be charged for broken appointments or short notice changes. This fee must be paid prior to any future treatment.

Financial Policy

In our efforts to keep dental cost at a minimum while maintaining a high level of professional care, we have established the following payment policies:

- Patients without Insurance Coverage: **Payment is expected at the time of treatment and may be paid for by**:
  - Personal Checks (with proper identification)
  - Cash
  - Credit Card (Visa, MasterCard, Discover, Care Credit)
- Patients with Insurance Coverage
  - Insurance Plans are accepted (we do not accept any HMO plans) providing that verification of eligibility has been made prior to the appointment and that we can accept the Assignment of Benefits. It is the patient's responsibility to verify the doctor is a listed participant with the insurance company plan prior to the appointment.
  - **Deductibles and Estimated Patient Portions not covered by insurance will be collected at the time services are rendered.**
  - All fees related to treatment are the full responsibility of the patient. In the event that payment is not received within 60 days from the treatment or the insurance payment varies from the estimated portion, the remaining balance will become the responsibility of the patient.
- Treatment consisting of several visits will require an appropriate down payment with the balance due upon completion.
- Payment plans are available and arrangements (signed completed financial agreement) **must be made in advance** of treatment. Providing that credit qualifications are met, payment plans will require an appropriate down payment and may be subject to monthly finance charges.
- **Account balances are due upon a receipt of statement from our office**. Account balances not paid within 25 days from the statement date will be subject to a service charge of $5.00.
- Any charges incurred by this office related to collection of overdue accounts will be added to the patient's account.
- A fee of $30.00 will be charged for any returned checks.

We hope this information is helpful in answering some of the questions you may have regarding our office policies. Please feel free to discuss any questions you may have with us.

I have fully read the above information and agree with the terms and conditions.

_____ _____

Patient/Responsible Party Signature **Date**

David J. Kitahara, D.D.S.
Bryan J. Kitahara, D.D.S.
8339 Cherry Lane
Laurel, MD 20707
Website: www.laurellakesdentist.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND RECEIPT OF NOTICE OF PRIVATE PRACTICES

Notice of Privacy Practices: You have the right to read our NPP before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information. A copy of our notice has been posted in our office, on our website and a paper copy available upon request.

We reserve the right to make revisions of our privacy practices as described in our NPP. If we make any changes, we will issue a revised Notice of Privacy Practices. Those changes may apply to any of your protected health information that we maintain. ***Revised 9/23/2013***

I have read a copy of this office's Notice of Privacy Practices and have considered the contents of this consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Print Name:_____

Signature:_____

Date:_____

For Office Use Only

_____

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)