Dino-mite Kids Dental
Pediatric Dentistry

Welcome!

Rex Chuang, DDS & Associates
23321 El Toro Rd, Ste C, Lake Forest, CA 92630
949-916-9798 | dinomitekidsdental@gmail.com

PATIENT INFO

Today's Date:

Name: _____ DOB: _____ ❑ M ❑ F
Last First MI Preferred (if any)

Home Address: _____
Street City State Zip

School: _____ School City: _____ Grade: _____

MEDICAL HISTORY

Physician: _____ Phone: _____ Date of Last Visit: _____

Is patient under physician's care outside of the routine? _____

Please list all medications: _____

Please list all allergies: _____

Please list any hospitalizations (when and why): _____

Please check all conditions that apply (if none, check "NONE" in last column).

- ❑ Abnormal Bleeding
- ❑ AIDS / HIV+
- ❑ ADD / ADHD
- ❑ Anemia
- ❑ Arthritis
- ❑ Asthma / Breathing Problems
- ❑ Autism / Asperger Syndrome
- ❑ Birth Defects
- ❑ Bladder Problems
- ❑ Blood Transfusions
- ❑ Brain / Spinal Injury
- ❑ Cerebral Palsy
- ❑ Cleft Lip / Palate
- ❑ Craniofacial Condition
- ❑ Cancer / Tumor
- ❑ Cystic Fibrosis
- ❑ Diabetes
- ❑ Down Syndrome
- ❑ Drug / Alcohol Abuse
- ❑ Eating Disorder
- ❑ Eczema
- ❑ Emphysema
- ❑ Epilepsy / Seizures
- ❑ Gastrointestinal Disorder
- ❑ Hay Fever
- ❑ Hearing Impaired / Deaf
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis A / B / C
- ❑ Herpes / Fever Blisters
- ❑ High Blood Pressure
- ❑ Infective Endocarditis
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Low Blood Pressure
- ❑ Premature Birth
- ❑ Mental Disability
- ❑ Muscular Dystrophy
- ❑ Orthopedic Disorder
- ❑ Pacemaker
- ❑ Pregnancy
- ❑ Psychiatric Condition
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Sickle Cell Disease
- ❑ Speech Problems
- ❑ Spina Bifida
- ❑ Thyroid Disease
- ❑ Tuberculosis (TB)
- ❑ Vision Impairment / Blind
- ❑ **NONE**
- ❑ Other: _____

Is there anything else we should know about your child (e.g. conditions that are emotional, behavioral, etc. in nature)?

_____

DENTAL HISTORY

Is this patient's first dental visit? If no, answer below. ❑ Yes ❑ No If no, was last time a good experience? ❑ Yes ❑ No

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

Please check all oral habits that apply. Is the patient currently in pain? ❑ Yes ❑ No

- ❑ Jaw Clenching
- ❑ Lip / Cheek Biting
- ❑ Mouth Breathing
- ❑ Nail Biting
- ❑ Nursing / Bottle
- ❑ Pacifier Use
- ❑ Teeth Grinding
- ❑ Tongue Thrusting
- ❑ Other: _____
- ❑ Thumb / Finger Sucking

How often does patient brush? ❑ 1x / day ❑ 2x / day ❑ Other: _____ ❑ by him/herself ❑ with adult help

How often does patient floss? ❑ 0x / day ❑ 1x / day ❑ Other: _____ ❑ by him/herself ❑ with adult help

Any fluoride use? ❑ Toothpaste ❑ Tablets ❑ Mouthrinse ❑ Water ❑ Drops

SIGNATURE

The information I have given herein is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health, and that it is my responsibility to notify the office of any changes.

Parent / Guardian Signature: _____ Dr Signature: _____

Dino-mite Kids Dental
Pediatric Dentistry

Welcome!

Rex Chuang, DDS & Associates
23321 El Toro Rd, Ste C, Lake Forest, CA 92630
949-916-9798 | dinomitekidsdental@gmail.com

Name (Patient): _____ DOB: _____ Today's Date: _____
Last First

PARENT 1 INFO

☐ Mother ☐ Father ☐ Biological ☐ Step ☐ Adoptive ☐ Foster ☐ Other

Name: _____ Birthdate: _____ Age: _____ ☐ M ☐ F
Last First MI

Home Address: _____
Street City State Zip

Mobile Tel: _____ Home Tel: _____ Email: _____

Employer: _____ Employer Tel: _____ Occupation: _____

Employer Address: _____
Street City State Zip

PARENT 2 INFO

☐ Mother ☐ Father ☐ Biological ☐ Step ☐ Adoptive ☐ Foster ☐ Other

Name: _____ Birthdate: _____ Age: _____ ☐ M ☐ F
Last First MI

Home Address: _____
Street City State Zip

Mobile Tel: _____ Home Tel: _____ Email: _____

Employer: _____ Employer Tel: _____ Occupation: _____

Employer Address: _____
Street City State Zip

ADDITIONAL INFO

Parents' Marital status: ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Remarried ☐ Single ☐ Widowed

Emergency Contact: _____ Relation: _____ Tel: _____
Cannot be a Parent Relationship to Patient

To whom should we email appt reminders? ☐ Parent 1 ☐ Parent 2 ☐ Other: _____

To whom should we text appt confirmations? ☐ Parent 1 ☐ Parent 2 ☐ Other: _____

Can we email you quarterly newsletters about our promotions? ☐ Yes ☐ No

If yes, whose email? ☐ Parent 1 ☐ Parent 2 ☐ Other: _____

DENTAL INSURANCE

☐ Check here if no insurance

Primary Insurance Company: _____ Insurance Tel: _____

Policy Holder: _____ SSN: _____ Birthdate: _____

Policy Holder ID #: _____ Group # (if any): _____

Secondary Insurance Company: _____ Insurance Tel: _____

Policy Holder: _____ SSN: _____ Birthdate: _____

Policy Holder ID #: _____ Group # (if any): _____

SIGNATURE

The information I have given herein is correct to the best of my knowledge. I understand that providing incorrect information can cause my insurance to deny claims, and that it is my responsibility to notify the office of any changes.

Parent Signature: _____ Print Name: _____

Dino-mite Kids Dental
Pediatric Dentistry

Welcome!

Rex Chuang, DDS & Associates
23321 El Toro Rd, Ste C, Lake Forest, CA 92630
949-916-9798 | dinomitekidsdental@gmail.com

Name (Patient): _____ DOB: _____ Today's Date: _____
Last First

HOW DID YOU FIND US?

❑ Google ❑ Yelp ❑ Insurance Directory ❑ School / Daycare: _____
❑ Facebook ❑ Direct Mail ❑ Friend / Family: _____ ❑ Other: _____

DENTAL PROCEDURES

Tell-Show-Do: If the child is anxious, we will explain to him or her what will be done using simple terminology and repetition. Then, we will demonstrate what will be done using instruments on a model or on the child's or dentist's finger. Finally, the procedure is performed in the child's mouth as described.

Positive Reinforcement: Behavior will be guided using positive reinforcement. We use varied voice tones and loudness, as well as reward behavior that is desirable. Rewards include praise, compliments, a prize, and/or pat on the back.

Routine Cleanings: Cleaning appointments for children 3 years and up consist of x-rays, exam, coronal polishing, and fluoride application. Such appointments for children under 3 years consist of exam, cleaning, and fluoride application.

Treatment Planning: Treatment plans are made at the time of the last exam. Because children's mouths are still developing, their mouths change faster than adults' mouths. So during the course of multiple treatment visits, oral conditions may change and necessitate procedures in addition to or different than those in the original plan.

Treatment Sequence: If multiple visits are needed to complete treatment, our doctors will sequence the visits based on their professional judgment. Depending on the age of the child, we normally treat one quadrant per visit. Anything more than one quadrant per visit may result in the child's increased distress and psychological trauma. The sequence of treatment may deviate from the original plan if an emergency situation arises (e.g. infection).

Side Effects: Common side effects after treatment can include prolonged numbness, nausea, and/or oral bruising following the administration of local anesthesia.

Nitrous Oxide: Administration of nitrous oxide (laughing gas) during treatment is a safe and common practice in pediatric dentistry. It typically produces pleasant feelings that help patients remain relaxed and calm, which is essential as high speed drills are usually used to clear away decay.

IV Sedation: Treatment usually requires high speed drilling, and cannot be done safely when behavior does not permit. For this safety reason, we will recommend IV sedation when extensive treatment is required and/or behavior is not ideal. Dino-mite Kids Dental will not perform any treatment outside of IV sedation if doing so is deemed unsafe.

OFFICE POLICIES

Cancellation / Reschedule: We understand the need to cancel or reschedule. However, it is our mission to ensure the dental wellness of all our patients. Whenever an appointment is missed, the opportunity for another child to receive emergency or timely care is lost. For this reason, we require a **24-hour advance notice** via telephone or email to cancel or reschedule so that we can give the time to another child who needs it. Live operators are available even outside of office hours to take your call.

Short Notice / No-Show: If less than 24-hour advance notice is given to cancel or reschedule (short notice), or an appointment is missed without any prior notice (no-show), your account will reflect the statuses below.

→ 1st Short Notice / No Show: Restriction (only morning appts during non-peak seasons, 2 patients max per day)
→ 2nd Short Notice / No Show: Standby (appointments only as they become available 1-2 days before)
→ 3rd Short Notice / No Show: Possible Dismissal

Consideration will be made for unforeseen emergencies, unless they are ongoing. A restriction or standby may be cleared with a $25 or $50 fee respectively, or with 12 months or 24 months of perfect attendance respectively.

Late Arrival: Arriving to appointments late by 15 minutes or more may be considered a no-show. It may also result in the appointment being rescheduled to avoid running into the next patient's time. Any tardiness may shorten the Q&A time with the doctor after the exam. If this occurs, you may opt to have the doctor call you at the end of the day.

Parent / Guardian Initials: _____

Rex Chuang, DDS & Associates
23321 El Toro Rd, Ste C, Lake Forest, CA 92630
949-916-9798 | dinomitekidsdental@gmail.com

Name (Patient): _____ DOB: _____ Today's Date: _____
Last First

OFFICE POLICIES (continued)

Payment: Payment for all professional services are due at the time of service, unless other prior arrangements have been made. Dino-mite Kids Dental will verify and bill your insurance as a courtesy, but the patient or the patient's guarantor are responsible for all fees, regardless of insurance coverage.

Reminders: To help you plan, we will email you a reminder for your appointment up to 3 weeks prior.

Confirmation: Appointment confirmations are an important part of the doctor-patient relationship. So we will ask you to confirm your appointment via text 2-3 days prior to your appointment. If no response is received, we will call you 1 day prior. We dedicate much of our time preparing for your appointment, including verifying insurance coverage and ensuring appropriate staffing and doctor time. In return, we ask for a minute of your time to confirm your appointment.

Aborted Appointments: We understand dental visits can be frightening for young children, so we are happy to reschedule your appointment if the patient's behavior requires us to abort the appointment the first time. Please understand that all additional aborted appointments thereafter will incur a charge of $25 each.

Authorized Representatives: If the patient is under 18 years old, at least one parent or legal guardian must be present for the entire duration of the patient's very first appointment with Dino-mite Kids Dental. Thereafter, parents or legal guardians may appoint another adult 18 years or older as their authorized representative to bring the patient to his or her appointments. Authorized representatives will be asked for their government issued photo ID at check-in. If you expect to need an authorized representative in the future, please fill out page 5.

Treatment: Parents, legal guardians, or authorized representatives are asked to remain in the office until the doctor provides clearance. In the event of an emergency change in treatment, we need a parent, legal guardian, or authorized representative present to approve the change.

Estimates: Every effort will be made to provide your child with the best possible treatment plan that fits your timetable and budget. We are happy to prepare treatment quotes in advance and preauthorize treatment with your insurance if necessary. However, all quotes are estimates only and are not a guarantee of coverage.

Photos: We take photographs of patients' teeth and face for office use - for example, account profiles, insurance photo requirements, contest winner posts on our social media accounts, and professional articles and lectures.

Etiquette: We strive to create an environment of respectful and courteous doctors, staff, and patients. Any hostility, aggression, or bullying directed at any doctor, staff, or patient will result in dismissal from the office.

Policy Changes: We reserve the right to modify and/or add to our office policies at any time, at our sole discretion, and without prior notice. We will post a notice in our office of any significant changes, which will be available upon request.

CONSENT

By initialing below, I hereby acknowledge that I fully understand and consent to the following.

_____ **Authorization:** I hereby authorize Dino-mite Kids Dental to perform upon my child dental exams, cleanings, topical fluoride applications, radiographs (x-rays), and other diagnostic aids to make a thorough diagnosis of my child's dental needs. I also authorize Dino-mite Kids Dental to provide for my child all treatment, medication, and therapy prescribed in-house and mutually agreed upon by me.

_____ **Financial:** I assume financial responsibility for all dental services, medications, and products provided for my child. I understand payment is expected on the date that services, medications, and/or products are provided. In the event that payment is not received by the agreed upon date, I understand that my bill may be escalated to collection and that my children's accounts may be inactivated. I also authorize my insurance company to pay directly to Dino-mite Kids Dental whenever possible. I understand that my insurance company may pay less than the actual bill, and I am ultimately responsible for payment for services rendered for the patient.

_____ **Delaying Treatment:** I understand delaying or foregoing treatment may allow dental problems to worsen into an emergency situation, including infection, pain, abscess formation, fever, developmental issues of permanent teeth, and/or long term dental problems.

Dino-mite Kids Dental
Pediatric Dentistry

Welcome!

Rex Chuang, DDS & Associates
23321 El Toro Rd, Ste C, Lake Forest, CA 92630
949-916-9798 | dinomitekidsdental@gmail.com

Name (Patient): _____ DOB: _____ Today's Date: _____
Last First

CONSENT (continued)

_____ **Policies & Procedures:** I understand and agree to the office procedures and policies herein.

_____ **Insurance Billing:** I authorize Dino-mite Kids Dental to send claims on my behalf and release any information to third party payers for insurance reimbursement purposes. I understand it is my responsibility to notify the office of any changes to my dental insurance or personal information as soon as possible.

_____ **Appointment Communication:** I understand the importance of the office's appointment email reminders and text confirmations, and that I may opt out by checking below even though it is not recommended.

☐ I would like to opt out of email reminders and text confirmations

_____ **Confidentiality:** Except for insurance third party payors, I understand the office cannot release any patient information to anyone other than the patient or legal guardian unless I provide the office with specific written authorization in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand the office's HIPAA details are in a separate enclosure that is available for my review.

☐ Yes, I want a copy ☐ No, I do not need a copy

_____ **Dental Materials:** I understand this is a separate enclosure and is available for my review.

☐ Yes, I want a copy ☐ No, I do not need a copy

AUTHORIZED REPRESENTATIVE(S) OTHER THAN PARENTS / GUARDIANS

Except for the very first appointment, parents or legal guardians may appoint another **adult 18 years or older** as their authorized representative to bring minor patients to their appointments. Their government issued photo ID will be required at check-in. If you expect to need an authorized representative in the future, please fill out the following.

Representative 1: _____ Birthdate: _____
Last First MI

Relationship to Patient: _____ Tel: _____ ☐ Mobile # ☐ Home #

Privileges: ☐ Check in ☐ Schedule appointments ☐ Make decisions

Duration of Authorization: ☐ 1 year from form date ☐ 2 years from form date ☐ Until I revoke authorization

Representative 2: _____ Birthdate: _____
Last First MI

Relationship to Patient: _____ Tel: _____ ☐ Mobile # ☐ Home #

Privileges: ☐ Check in ☐ Schedule appointments ☐ Make decisions

Duration of Authorization: ☐ 1 year from form date ☐ 2 years from form date ☐ Until I revoke authorization

Representative 3: _____ Birthdate: _____
Last First MI

Relationship to Patient: _____ Tel: _____ ☐ Mobile # ☐ Home #

Privileges: ☐ Check in ☐ Schedule appointments ☐ Make decisions

Duration of Authorization: ☐ 1 year from form date ☐ 2 years from form date ☐ Until I revoke authorization

By signing below, I hereby authorize Dino-mite Kids Dental to examine and treat my minor child when accompanied by the above person or people. The above person(s) may receive my child's health information and have the indicated privileges above. I also give the above person(s) authority to make serious or urgent health care decisions in the event that I cannot be reached, or in case of an emergency when there is not sufficient time to seek my specific consent. I understand this authorization is valid unless revoked in writing, which may be done at anytime.

Parent Signature: _____ Print Name: _____