1. GENERAL INFORMATION

Father S.S.# ______ **Mother S.S.#** ______

Father ______ Mother ______ Marital Status ______

Father's Birthdate ______ Mother's Birthdate ______

Residence Address ______ Res. Phone ______

City ______ State ______ Zip ______

Father Employed By ______

Occupation ______

Business Address ______ City ______ State ______

Business Phone ______

Mother Employed By ______

Occupation ______

Business Address ______ City ______ State ______

Business Phone ______

How did you hear of this office? ______

State name and address of person (outside of the immediate family) to be contacted in event of an emergency:

______

II. CHILD'S HISTORY

(These questions are of great value in aiding us to a better understanding of your child.)

Reason for Visit: ☐ Check-Up ☐ Teeth Straightening ☐ Discomfort ☐ Other ______

Child's Name **First:** ______ **Last:** ______ Sex: ☐ M ☐ F

Age ______ Birthday ______, 19 ______

State condition of child's health ______

Has your child ever been under the care of a physician? ______ If yes, state for what and when ______

______

Has your child received medication in the past other than antibiotics? ______ If yes, for what and when ______

______

Has your child ever had any kind of surgery? ______ If yes, for what and when and by whom ______

______

Has your child any history of: Asthma, Bleeding disorder, Convulsions, Diabetes, Hepatitis, Heart trouble, HIV positive, Rheumatic fever, Seizures, Temper tantrums? (Please indicate) ______

Does your child have a reduced resistance to infection? ______

Has your child every been allergic to anything, to any food, or to any medicine? ______

______

Is your child allergic to Penicillan or other antibiotics? ______

Is your child allergic to local anesthetic? ______

Is your child taking internal fluorides? ______

Has your child ever received fluoride put on their teeth by a dentist? ______

Has any member of the family ever had an unusual dental history, such as missing or extra teeth. Please describe: ______

______

Has there ever been any injury to any of your child's teeth by fall, blow, bump or otherwise? ______

______

Has your child experienced any unfavorable or unpleasant reaction from any previous dental or medical care? ______

Is there any health or other problems that you feel should be brought to the attention of the doctor? ______ If so, please state:

______

State name, address and telephone number of child's attending physician. ______

______

III. ARE X-RAYS O.K.? ☐ Yes ☐ No

FINANCIAL ARRANGEMENTS

Until the dental needs of the patient are known, and the treatment and restorations planned, it is of course, not possible to know what financial arrangments will be best.

For this reason, all services rendered prior to the completion of the diagnosis and treatment plan are to be paid for at that time.

As soon as the diagnosis is complete, and an accurate estimate of the fee is possible, the doctor and parent or guardian will agree as to what is to be done. The fee for the service, and the method of payment to be employed, should be discussed with the financial secretary.

Terms: Net 30 days FINANCE CHARGE of 1½% per month (18% per year) will be charged on all past due accounts. Minimum charge $1.00.

BROKEN APPOINTMENTS

A 24-hour notice is required to cancel an appointment. Anything less than 24 hours is considered a broken appointment. There is a charge for all broken appointments which is the financial responsibility of the parent/guardian. Three such failures would result in treatment curtailment.

I authorize the necessary dental treatment to be performed for the above patient.

Date ______ Signature ______
(Parent or Guardian)

FORM 9

IV. INSURANCE INFORMATION

Insured Person's Name ____________________

S.S. No. ____________ Union Local No. ____________

Group/Plan No. ________ How much is your deductible? ________

Insurance Name ____________________

Mailing Address ____________________

____

Telephone No. ____________________

Is there dual coverage? ________ If yes, please complete the following:

Insurance Person's Name ____________________

S.S. No. ____________ Union Local No. ____________

Group/Plan No. ________ How much is your deductible? ________

Insurance Name ____________________

Mailing Address ____________________

____

Telephone No. ____________________

PICTURE

3449 Valle Verde Dr.
Napa, California 94558

David Suttie, D.D.S.
Children's Dentistry

Napa, California
(707) 25-SMILE

David Suttie, D.D.S.
Dentistry for Children
3449 Valle Verde Drive
Napa, Ca 94558
(707) 25-SMILE

Our Financial Policy

We are committed to provide you with the best possible care. If you have dental insurance, we will be happy to help you receive your maximum allowable benefits. In order to achieve this, we need your assistance in understanding our financial policy.

Payment is due when services are rendered. Cash, Check, Visa, Discover, and Mastercard are accepted forms of payment. We will be happy to process your insurance claims; however, **any insurance claim not paid within 60 days of filing will become your responsibility.**

There will be a **$25.00** charge for any returned check. In addition, any non-insurance account that is over 30 days past due will automatically be transferred to our collection agency. There will be a **35% collection fee** once your account is turned over to collections.

We ask you to please notify our office **48 hours** in advance if you need to cancel or reschedule your appointment.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize that:

1.) **Your insurance is a contract between you and your insurance company.**
2.) Not all services are covered benefits in all contracts. Some insurance companies select services they will not cover.

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims and checking your benefits is a courtesy that we extend to our patients, all charges are ultimately your responsibility and are due when services are rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please do not hesitate to ask us. We are here to help.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature: ______________________________ Date: ____________________

David Suttie, D.D.S.
Dentistry for Children
3449 Valle Verde Drive
Napa, Ca.94558
(707) 25-SMILE

Insurance Payment Policy

We are committed to providing you with the best possible care. If you have dental insurance, we will be happy to help you receive your maximum allowable benefits.

We also want you to be aware that we may not be a preferred provider with your insurance. In which case, your insurance will pay less and your portion of the bill will be greater. We will be happy to provide you with a pre-treatment estimate from your insurance. (Please allow 2-3 weeks for pre-treatments)

We also would like to inform you with some insurance's they do not pay for composite fillings. In that case, your fee will then change once your insurance pays our office.

All proposed treatment plans are only an estimate of insurance payment and NEVER a guarantee.

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

SIGNATURE ______________________________ DATE _______________

Notice of Privacy Practices

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Uses and disclosure:

- Your protected health information is accessed and used for health related purpose only
- Your protected health information is never sold, rented, or transferred, exchange, and/or used for non-healthcare related purposes including marketing activities without your written authorization.

Your protected health information is disclosed to third party entities without your written authorization for the purpose of treatment, to obtain payment for treatment and for healthcare operations.

Certain Circumstances:

Your protected health information can be disclosed without your written authorization in certain limited circumstances:

- Medical Emergencies
- In situations required by law
- Individuals involved in your care
- When requested by a public health agency
- When requested by a law enforcement agency

For any purpose other than treatment, obtaining payment, healthcare operations, or certain circumstances, we will ask for your written authorization before using or disclosing your protected health information. If you choose to sign an authorization to disclose protected health information, you can revoke that authorization in writing at anytime.

Patient Rights:

- You have the right to request in writing to inspect and/or receive a copy of your health information.
- You have the right to request an alternate means or location to receive communications regarding your health information.
- You have the right to request in writing to amend, correct, or delete any recorded health information within our possession.
- You have the right to request in writing to restrict some of the uses and disclosures of your health information.
- You have the right to request in writing an accounting of certain disclosures of your health information that were made by this office.

Conditions and limitations may apply. Obtain additional information from the front desk

Changes to this notice: We reserve the right to change privacy practices and the conditions of this notice at any time and without prior notice. In the event of changes, an updated notice will be posted and a copy will be made available to you.

May 2016

DAVID SUTTIE, D.D.S.
Dentistry for Children
3449 Valle Verde Drive
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(707) 25-SMILE

Acknowledgement of Receipt of Privacy Practices Notice

This document acknowledges that you have received a copy of the Notice of Privacy Practices. This document is not a contract, authorization, release, or consent form. This document will remain in your records.

I, ____ (Patient name)
Acknowledge that I have received a copy of the Notice of Privacy Practices.

____ ______________

Patient's signature Date

If the patient is a minor, a parent or legal guardian must sign.

____ ______________

Parent or Legal guardian signature Date

____

Relationship

If the patient is not a minor , but under the care of a relative, friend or caregiver, sign here:

____ ______________

Signature Date

____

Relationship