Welcome

Soudabeh Sharafi, D.M.D.
12750 Carmel Country Rd # 215
San Diego, CA 92130

Del Mar Pediatric & Adolescents Dental Group

Health History Form

1.Tell Us About Your Child

Child's Name____
Last First Mi

Nickname_______________________________ MALE FEMALE

Sibling that we treat__________________________________

Child's Birthdate _______/_______/_______ Child's Age__________

Child Home # (_____)_______________SSN____________________

Child's Home Address___________________________________

____
City State Zip Code

2. Mother's Information

Name____

Stepmother Guardian Birthdate_______/________/_______

Employer____

Work # (_________)_____________________________________

Home # (__________)____________________________________

Cellular # (__________)_________________________________

SS #___________________________DL #_____________________

3. Father's Information

Name____

Stepfather Guardian Birthdate_______/_______/_______

Employer____

Work # (__________)____________________________________

Home # (__________)____________________________________

Cellular # (_________)__________________________________

SS #____________________________DL #____________________

Marital Status Single Married Separated
Divorced Widowed

4. Who is Accompanying the Child Today?

Name______________________________Relationship_________

Do you have legal custody of the child? Yes No Shared

Is there a child custody order in place that may affect decisions and /or consents for dental treatment? Yes No

5. Person Responsible for Account

Name_____________________________Relationship___________

Billing Address______________________________________

____
City State Zip Code

Home #(_____)________________Work #(______)_____________

Email____

6. Primary Dental Insurance

Insurance Co. Name___________________________________

Ins. Address____

Ins. Phone #____

Policy/ID #__________________________Group #____________

Policy Owner____

Policy Owners DOB______/______/______ SSN________________

Employer____

7. Secondary Dental Insurance

Insurance Co. Name___________________________________

Ins. Address____

Ins. Phone #____

Policy/ID #__________________________Group #____________

Policy Owner____

Policy Owners DOB______/______/______ SSN________________

Employer____

8. Dental History

Is this your child's first visit to a dentist? ____________

If not, date of last visit dental visit? _________________

Were any X-rays taken at previous dental visits? ______

Has your child had any dental injuries? ______________

If yes, please explain _____________________________

____

Why did you bring your child to the dentist today? ____

____

Does the child have any of the following habits?

Lip Sucking/Biting ____Clenching/ Grinding teeth _____

Thumb/Finger Sucking ____ Nursing Bottle Habits_____

Has the child ever had any serious or difficult problem associated with previous dental work? ______________

If yes, please explain _____________________________

Is the child taking fluoride supplements? YES NO

Is the child's water fluoridated? YES NO

Has the child had any pain or tenderness in his/her jaw/ joint (TMJ/TMD)? YES NO

Does the child brush his/her teeth daily? YES NO

Floss teeth daily? YES NO

9. Medical History

Has your child ever had any of the following:

Heart disease or defects	YES	NO
Autism/ADHD	YES	NO
Hospital Stays	YES	NO
Operations	YES	NO
Heart Murmur	YES	NO
Asthma/Breathing Difficulties	YES	NO
Rheumatic Fever	YES	NO
Anemia or Blood Disorders	YES	NO
Cleft Lip or Palate	YES	NO
Diabetes	YES	NO
Bleeding Difficulties	YES	NO
Mental Retardation	YES	NO
Kidney/ Liver Disease	YES	NO
Hepatitis or HIV/AIDS	YES	NO
Sickle Cell	YES	NO
Convulsions or Seizures	YES	NO
Dizziness or Fainting	YES	NO
Latex Allergies	YES	NO

Please discuss any serious medical conditions the child has had_______________________________________
____

Please list all medications the child is currently taking:
____
____

Please list Drug Allergies:
____

Child's Physician: _______________________________
Phone: ______________________ Is the child currently under physicians care? YES NO
Child current health condition GOOD FAIR POOR
Who may we thank for referring you?
Website Friend Dr.______________

AUTHORIZATION and RELEASE

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and / or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. (If payable to the Insured, then payment is due at the time services are rendered) I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services the day they are rendered on my behalf and my dependents.

X ____
Signature of Parent or Guardian

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.
2. Obtaining payment from third party payers (e.g. my insurance company);
3. The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your **Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Name:_________________________________Relationship to Patient:______________

Signature:____Date:_______________________

Del Mar Pediatric Dental Group
Soudabeh Sharafi, DMD
Specializing in Children's Dentistry
12750 Carmel Country Rd. Ste 215
San Diego, CA 92130

Financial Agreement and Authorization for Treatment

We charge a 50% finance fee on all accounts with a balance 60 days or older. Payment is due in full at each appointment. For your convenience we offer the following payment methods, please check the one you prefer……….

[ ] Cash **[ ] Insurance Co-pay** **[ ] Credit Card** **[ ] Care Credit/Citi Health**

I authorize for my child. I agree to pay all the fees and charges for such treatment.

Signature: ____ Date: ______________________

Financial agreement for dental treatment can be made prior to the commencement of treatment. Dental benefit plans may cover only part of your dental treatment. It is understood that you are responsible for the entire balance of your account. The Contract of dental benefits is between the patient and the insurance company.. **You are responsible for all services rendered, regardless if you have dental benefits or not. We bill your insurance company for you as a courtesy. PLEASE REMEMBER THE FINANCIAL OBLIGATION FOR DENTAL TREATMENT IS BETWEEN YOU AND THIS OFFICE AND NOT DEPENDENT UPON INSURANCE.**

Authorization and Release

I authorize my dentist to release any information including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care, third-party payers and/or other heath care practitioners.

I authorize and request my insurance to pay directly to the dentist insurance benefits otherwise payable to Dr. Soudabeh Sharafi.

I authorize and request my dentist to use my signature on file for my signature on all dental insurance forms to expedite computer processing claims.

I understand that my dental 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 of my dependents. If any insurance payment has not been received within 60 days the responsible party is billed immediately.

If I do not pay the entire balance within 60 days of the billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed to the bill for services rendered. I realize a failure to keep this account in good standing may result in you being unable to provide additional dental services except for dental emergencies where there will be prepayment.   It is your responsibility to ensure your insurance company pays promptly so you can avoid finances charges. You agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

I agree that I am the responsible party: Because a large percent of the population involves divorces situations it is the policy of this office to collect from the parent who brings the child in for dental services. We can give you a letter as a courtesy so the other parent can reimburse you for his/her percentage, but full payment must be paid at the time of the visit. This is standard for most businesses.

I acknowledge that I have read and agree to the above financial policy.

Signature X____ Date ______________________

This packet has been reviewed by: (staff member's signature) ____________________________

Del Mar Pediatric & Adolescents Dental Group

Medical History Update Form

Patient's Name: ____ DOB: ___________
Last First

Date	Change in Medical History or Medications	Dentist Signature	Parent or Guardian Signature