southoc Pediatric Dentistry & Orthodontics
Where smiles start.

Pediatric Dentistry
John De Lorme, DDS
Sam Wu, DDS
Chris Carillo, DDS

Orthodontics
Chris Carter, DMD, MS

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: _____
Street City State Zip

Who may we thank for referring you? _____

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

Was 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 childs first dental visit? ❒ Yes ❒ No If so, 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 vitamins or drink fluoridated water? ❒ 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: _____ City: _____ Phone: (_____) _____

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

TMJ / TMD Pain ❒ **Y** ❒ **N** Clenching / Grinding Teeth ❒ **Y** ❒ **N** Thumb / Finger Sucking / Pacifier ❒ **Y** ❒ **N** Speech Problems ❒ **Y** ❒ **N**

Medical History

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

Address: _____

Is your child currently 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 all that apply)

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 Headaches, Frequency?	Y❒ N❒
Allergies	Y❒ N❒	Congenital Heart Defect	Y❒ N❒	Hepatitis	Y❒ N❒	Rheumatic Fever	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 Dyscrasis	Y❒ N❒	Handicaps	Y❒ N❒	Low Blood Pressure	Y❒ N❒	Significant Injuries, What?	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❒	Tonsilitis	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): _____

Parents Information

Parent's Marital Status: ❐ Married ❐ Divorced ❐ Separated ❐ Widowed ❐ Remarried ❐ Single Family's E- Mail: ______

Parent #1 ❐ M ❐ F Birthdate: ____/____/____ Home Phone #: (______) ______ Work Phone #: (______) ______

Name: ______ Social Security #: ______ Drivers License #: ______

Address: ______
Street City State Zip

Employer: ______ Occupation: ______ Length of Employment: ______

Employers Address: ______
Street City State Zip

Parent #1 Cell # (______) ______ Parent # 2 Cell #: (______) ______

Parent #2 ❐ M ❐ F Birthdate: ____/____/____ Home Phone #: (______) ______ Work Phone #: (______) ______

Name: ______ Social Security #: ______ Drivers License #: ______

Address: ______
Street City State Zip

Employer: ______ Occupation: ______ Length of Employment: ______

Employers Address: ______
Street City State Zip

Name of parent who resides with the child: ______

Nearest relative: ______ Address: ______ Phone: ______

Is your child covered by a dental insurance plan? ❐ Yes ❐ No

Insurance Information

Primary Insurance

Insurance Co. Name: ______ Phone #: (______) ______ Group # (Plan, Local, or Policy#): ______

Insurance Co. Address: ______
PO Box / Street City State Zip

Insured's Name: ______ Relationship to Patient: ______

Insured's Address (if different from above): ______ Home Phone #: (______) ______

Insured's Birthdate: ____/____/____ Social Security #: ______ Insured's Employer: ______

Secondary Insurance

Insurance Co. Name: ______ Phone #: (______) ______ Group # (Plan, Local, or Policy#): ______

Insurance Co. Address: ______
PO Box / Street City State Zip

Insured's Name: ______ Relationship to Patient: ______

Insured's Address (if different from above): ______ Home Phone #: (______) ______

Insured's Birthdate: ____/____/____ Social Security #: ______ Insured's Employer: ______

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 the dentist insurance benefits otherwise payable to me. I understand that my dental 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 dentist 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: ____/____

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Oral Health Risk Assessment

CHILD'S NAME _____ **AGE** _____

CHILD'S HEALTH HISTORY:

	PLEASE CIRCLE	
Did birthmother have any problems during pregnancy?	Y	N
Was child premature?	Y	N
Were there any complications during birth?	Y	N

If Yes to any of the above, explain _____

PARENT'S DENTAL HISTORY:

Mother: Do you receive regular dental care?	Y	N
Have you ever had a cavity?	Y	N
Father: Do you receive regular dental care?	Y	N
Have you ever had a cavity?	Y	N

DIET AND NUTRITION:

Is/was your child breastfed?	Y	N
Does your child sleep with a bottle?	Y	N
Does your child drink juice or sugar sweetened beverages?	Y	N

How many meals/snacks does your child eat per day? _____

ORAL HYGIENE:

Do you brush your child's teeth/gums?	Y	N

If Yes, how often _____

Do you use fluoride toothpaste to clean your child's teeth?	Y	N

FLUORIDE:

Does your child drink tap water?	Y	N
If yes, is the water filtered?	Y	N
Does your child drink bottled water?	Y	N
If yes, is it fluoridated?	Y	N

PARENTS SIGNATURE _____ **DATE** _____

South OC Pediatric Dentistry & Orthodontics, a practice of J. D. De Lorme DDS, Inc

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (April 14, 2003), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using

our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable duplication fee for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Samuel Wu, DDS

Telephone: 949.581.5800 option 1 Fax: 949.581.6794

E-mail: DrSam@WhereSmilesStart.com

Address: 26302 La Paz Road, #114 / Mission Viejo / CA / 92691

OUR FINANCIAL POLICY

Thank you for choosing us as your family's dental health care provider. We are committed to giving your family ideal treatment. Payment of your bill is considered part of a successful treatment. The following is a statement of our financial policy. Please read it, sign it and return it to our office.

Patients requesting financing arrangements are invited to discuss financing options with our front office team.

FULL PAYMENT IS DUE AT THE TIMEOF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AND WE OFFER EXTENDED PAYMENTS THROUGH CARE CREDIT.

INSURANCE

We accept all third-party (dental insurance) programs that allow freedom of choice in the selection of a dental provider. We are a participating office for Assurant and Aetna.

As a service to our patients, we accept assignment of insurance. However, we require your share of the bill to be paid at the time of service. You are responsible for any and all charges not covered by insurance, whether the amounts are applied to your deductible, co-insurance, copayment, or a non-covered expense.

By signing this form, you assign to South OC Pediatric Dentistry & Orthodontics all rights, titles, and interests in and to any and all dental benefits otherwise payable to you for oral health treatment rendered by the doctors at South OC Pediatric Dentistry & Orthodontics. By signing this form, you also acknowledge that you have been informed of the treatment plan and associated fees. You agree to be responsible for all charges for dental services and materials not paid by your dental benefits plan unless prohibited by law or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges.

To the extent permitted by law, you consent to our use and disclosure of your protected health information to carry out payment activities in connection with dental claims billed on your behalf. For insurance policies other than Assurant and Aetna, please be advised that your insurance policy is a contract between you and your insurance company. As a dental care provider, we are not a party to that agreement.

If your insurance company has not paid our office within **45 days** of the time of service, you will be required to pay the balance at that time by one of the options mentioned above. Insurance policies vary; please be informed that some services may not be a covered benefit.

USUAL AND CUSTOMARY RATES

We are committed to providing ideal dental treatment to all of our patients. Our fees reflect our commitment to the quality our patients deserve and are considered usual and customary for the area regardless of any insurance company's determination.

MINOR PATIENTS

Payment of services of the treatment of minors is the responsibility of the adult accompanying that minor. Payment can be made by cash, check, credit card, or financing through care credit.

I understand and agree to this Financial Policy.

Signature of Parent / Responsible Party	Date
Print Parent / Responsible Party Name	Print Patient Name

SOUTH OC PEDIATRIC DENTISTRY & ORTHODONTICS

AUTHORIZATION TO RELEASE INFORMATION TO FAMILY MEMBERS

Due to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we are no longer allowed to release patient information to anyone other than the patient or legal guardian, unless specific written authorization is given to our office. In the space below, list any family members that you give your permission for the Doctor or dental team member to discuss your medical information. This permission can be rescinded at any time per the patient's verbal or written request. This authorization is to facilitate continuity of care and you are entitled to receive a copy of this agreement.

Family Member / Personal Representative	Relationship
_____	_____
_____	_____
_____	_____

I authorize (check one)

☐ All Medical information, including but not limited to records pertaining to examinations, treatments, consultations, billing records, x-rays and reports, history, laboratory findings, admissions and discharge reports, treatment records, diagnosis and prognosis and records, nurse's and doctor's notes and any other non-medical information in my file.

☐ Only the following types of Information: _____

Patient / Guardian Signature: _____

Patient / Guardian Printed Name _____

Date: _____

Authorization to Identify Self with Messages
(Authorization to leave messages on recorder)

My signature below authorizes Dr. De Lorme, Dr. Wu, Dr. Lovingier and Dr. Carter and/or their staff to identify themselves from the doctor's office when calling to leave a message regarding my / my child's appointments, results, referrals or other medical information on any answering device or with another person answering the phone. I also authorize South OC Pediatric Dentistry & Orthodontics to use Text and E-mail programs to communicate with me regarding my / my child's appointment.
Preferred number to use:

_____ Home _____ Work _____ Cell

Patient / Guarantor Initial: _____
For minor's, child(ren) covered by this release: _____
Please list all children covered by this authorization

SOUTH OC PEDIATRIC DENTISTRY & ORTHODONTICS

HIPAA PRIVACY RULE OF
PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (S 164.508(a))

I _____(patient name or legal guardian) understand that as part of my/ my child's healthcare, this facility originates and maintains health records describing my/ my child's health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my/or my children's care and treatment
- a means of communication among the health professionals who may contribute to my/my child's healthcare;
- a source of information for applying my diagnosis and surgical information to my/my child's bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (S164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

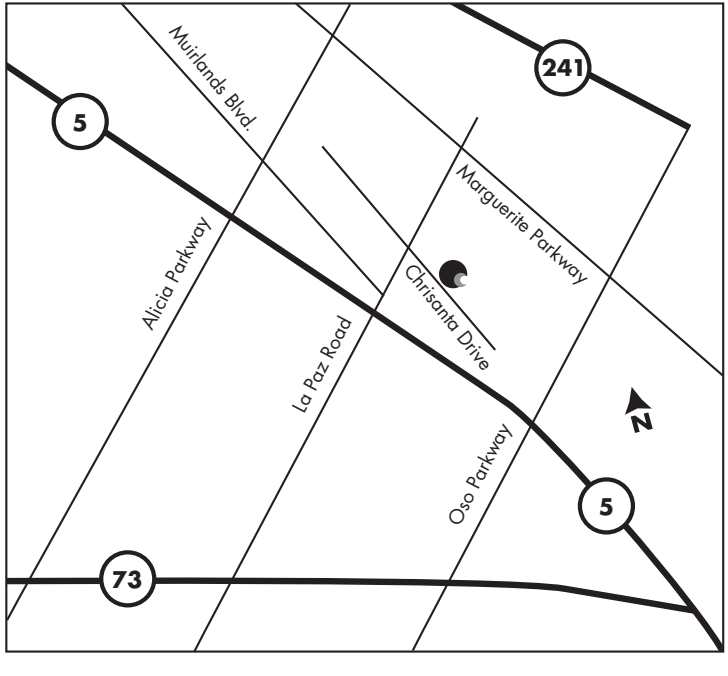
Signature of Patient or Legal Representative : _____

Child's Name Covered by this Authorization: _____

Please list all children covered by this authorization.

Date: _____

Directions to SOUTH OC DENTAL GROUP / Pediatric Dentistry:



Traveling North on the 5 Freeway:

- Take the 5 Freeway to the La Paz Road exit
- Turn Right on La Paz Road
- Turn Right on Chrisanta Drive
- Take the first Left into the Medical–Dental building parking lot
- Our Suite #114 is located at the lower right corner of the building
- 26302 La Paz Road, #114

Traveling South on the 5 Freeway:

- Take the 5 Freeway to the La Paz Road exit
- Turn Left on La Paz Road
- Turn Right on Chrisanta Drive
- Take the first Left into the Medical–Dental building parking lot
- Our Suite #114 is located at the lower right corner of the building
- 26302 La Paz Road, #114

where smiles start