REGISTRATION AND TREATMENT

Date______________________ Home Phone (______) ______________

Cell Phone (______)______________

PATIENT INFORMATION

Name ______________________________ SS/ /Patient ID #______________
Last Name First Name Middle Initial

Address ______________________ E-mail ______________________

City ______________________ State ______________ Zip ______________

Sex ☐ M ☐ F Age______ Birthdate ______________

Patient School ______________________

School Address ______________________ /School Phone (_____)______________

Whom may we thank for referring you?______________________________

In case of emergency who should be notified? ______________ Phone (_____) ______________

PRIMARY INSURANCE

Person Responsible for Account ______________________________
Last Name First Name Middle Initial

Relation to Patient ______________ Birthdate ______________ ID#/Soc. Sec. # ______________

Address (If different from patient's) ______________________ Phone (_____) ______________

City ______________________ State ______________ Zip ______________

Person Responsible Employed By ______________ Occupation ______________

Business Address ______________ Business Phone (______) ______________

Insurance Company ______________________________

Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________________________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name______________________ Relation to Patient ______________ Birthdate ______________

Address (If different from patient's) ______________________ Phone (_____) ______________

City ______________________ State ______________ Zip ______________

Subscriber Employed by ______________________ Business Phone (______)______________

Insurance Company ______________________ Soc. Sec. # ______________

Group # ______________ Subscriber #______________

Names of other dependents covered under this plan ______________________________

Please Complete Above Information and Next Page

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Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL) | Nickname | Date of Birth
Parent's/Guardian's Name | Relationship to Patient
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)
Phone (Home / Work) | Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia
❑ Arthritis
❑ Asthma
❑ Bladder
❑ Bleeding disorders
❑ Bones/Joints
❑ Cancer
❑ Cerebral Palsy
❑ Chicken Pox
❑ Chronic Sinusitis
❑ Diabetes
❑ Ear Aches
❑ Epilepsy
❑ Fainting
❑ Growth Problems
❑ Hearing
❑ Heart
❑ Hepatitis
❑ HIV +/AIDS
❑ Immunizations
❑ Kidney
❑ Latex allergy
❑ Liver
❑ Measles
❑ Mononucleosis
❑ Mumps
❑ Pregnancy (teens)
❑ Rheumatic fever
❑ Seizures
❑ Sickle cell
❑ Thyroid
❑ Tobacco/Drug Use
❑ Tuberculosis
❑ Venereal Disease
❑ Other ____________

Please list the name and phone number of the child's physician:

Name of Physician ______________________ Phone ______________

Child's History

	Yes	No
1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: ______	❑	❑
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ______	❑	❑
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: ______	❑	❑
4. How would you describe the child's eating habits? ______		
5. Has the child ever had a serious illness? If yes, when: ______ Please describe: ______	❑	❑
6. Has the child ever been hospitalized?	❑	❑
7. Does the child have a history of any other illnesses? If yes, please list: ______	❑	❑
8. Has the child ever received a general anesthetic?	❑	❑
9. Does the child have any inherited problems?	❑	❑
10. Does the child have any speech difficulties?	❑	❑
11. Has the child ever had a blood transfusion?	❑	❑
12. Is the child physically, mentally, or emotionally impaired?	❑	❑
13. Does the child experience excessive bleeding when cut?	❑	❑
14. Is the child currently being treated for any illnesses?	❑	❑
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ______	❑	❑
16. Has the child had any problem with dental treatment in the past?	❑	❑
17. Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18. Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19. Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20. Has the child had any orthodontic treatment?	❑	❑
21. What type of water does your child drink? ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22. Does the child take fluoride supplements?	❑	❑
23. Is fluoride toothpaste used?	❑	❑
24. How many times are the child's teeth brushed per day? ______ When are the teeth brushed? ______	❑	❑
25. Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26. At what age did the child stop bottle feeding? Age ______ Breast feeding? Age ______		
27. Does child participate in active recreational activities?	❑	❑

28. IF THIS IS NOT THE FIRST VISIT, WHO WAS THE FORMER DENTIST ______________

Parent's/Guardian's Signature ______________________ Date ______________

For completion by dentist

Comments ______________________

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by ______________

Date ______________

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Form S707

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or go online at www.adacatalog.org

EUGENIA FRIEDLAND, D.D.S.
FAMILY DENTISTRY

Please initial that you have read and understood the following:

_____I acknowledge that I have received from Eugenia Friedland, D.D.S., a copy of the Dental Materials Fact Sheet titled **The Facts about Fillings**. (Website)

_____Appointments are made exclusively for you the patient and are times set aside with Doctor. We require an advance 24-hour notice if you cannot make your scheduled appointment time. We reserve the right to charge for any appointment cancelled or missed without 24-hour notice.

_____I have received a copy of this office's **Notice of Privacy Practices**. (Website)

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described on our Notice. If we change our privacy practices, we will issue a revised Notice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice, including any revisions of out Notice, at any time contacting:

Contact Person: Cindy Paul
Telephone: 408-246-4460 Fax: 408-246-1810
E-mail: drfriedland@yahoo.com
Address: 1150 Scott Blvd., B-2 Santa Clara, CA 95050

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. 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 health care operations.

Signature: ______________________________ **Date:** ____________________

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name:______________________________
Relationship to patient:______________________________

EUGENIA FRIEDLAND, D.D.S.
FAMILY DENTISTRY

Welcome to our office. We hope that this information form will answer most of your questions about our office's financial and insurance policies.

Payment or co-payment is expected at the time service is performed. We accept cash, personal checks, Visa, MasterCard, Discover, and American Express.

Regular Indemnity Insurance:

If you have traditional indemnity insurance to help you with payment for your dental treatment, we will be glad to help you receive the benefits from your insurance company. Your insurance company is a third party, and may assist you in payment; we will bill them as a courtesy to you. If your insurance company does not respond within 45 days, we will look to you for payment. **Our treatment is rendered to you; therefore you are the responsible party.**

Most insurance companies have their own schedules of "allowable charges" for each procedure, and they may not be the same as the actual charges in our office. Based on our experience with your insurance company, we will calculate your co-pay as closely as possible. **Insurance companies will not guarantee phone quotes**, but we can submit a pre-estimate for a written verification for you.

Dental Plans:

Our office for the most part in considered an out-of-network provider for most PPO plans; which means that your out-of-pocket financial responsibility will tend to be more than an in-network provider.

We are contracted with the following insurance companies and have lower out-of-pocket expenses:

Assurant Employee Benefits PPO, and **Delta Dental** as a **Premier** provider.

Delta Dental Plans:

Insurance claims that are submitted through Delta Dental will be paid at the **Premier Provider** level. The Premier level is usually more out-of-pocket expense than a PPO Delta provider.

Extended Payments:

Our office does not offer extended payment plans or any sort of financing.

Collection:

Most of our patients are very conscientious about their accounts, but occasionally we have difficulty with collection. If an account is delinquent and cannot be cleared within 90 days, it will be reported as a bad debt with the Credit Bureaus, and will become a part of your credit history until it is cleared. We prefer not to use a collection service.

Our entire staff is committed to providing you the best possible dental care, and we will be happy to assist you in any way we can. If you have questions, please do not hesitate to ask.

I ACCEPT FULL FINANCIAL RESPONSIBILTY FOR THE SERVICES RENDERED TO ME NY THE STAFF AT EUGENIA FRIEDLAND, D.D.S. I HAVE READ, UNDERSTOOD, AND AGREE TO THE POLICIES OUTLINED ABOVE.

Date ______________________ Signature ________________________________

1150 Scott Blvd., Ste. B-2 Santa Clara, CA 95050 Tel: 408-246-4460 Fax: 408-246-1810
Website: www.dr-friedland.com
E-mail: drfriedland@yahoo.com

Eugenia Friedland, D.D.S.
1150 Scott Blvd., Suite B-2 Santa Clara, CA 95050 Phone: 408-246-4460 E-mail: drfriedland@yahoo.com
www.dr-friedland.com

Parental Presence Policy

This has been a topic of great controversy for many years. Virtually all studies designed to investigate the effect of parental presence in the surgery on the child's cooperation with dental treatment have failed to demonstrate any difference between behavior with or without the parent present. Only one reasonably well-designed study, by Frankl in 1962, has ever suggested that parental presence might affect child behavior. Frankl's results indicated that children of around 4 years old and younger behave more positively when parents were present. However, no difference was demonstrated in older children.

In most of the studies, parents were carefully instructed to sit quietly during the procedure and not to interfere with dentist-child communication. Frankl comment upon this in his concluding comments:

"the presence of a passively observing mother can be an aid to the child. **This can be accomplished if the mother is motivated positively, is instructed explicitly and cooperates willingly in the role of a silent helper."**

Having said this, in the absence of any convincing evidence one way or the other, having the parent present during the treatment of preschool children remains a matter of individual choice.

We often state to the child "Our Rule":

Mom or dad are allowed to stay in the room only if you behave and listen to Dr. Friedland.

We may sometimes ask the parent to leave the room if we "sense" it would be beneficial. This may happen even if you, the parent, are doing everything we asked you to do.

This is not a lecture ☺. We hope we can work together for a positive dental experience for your child.