Dr Nasem Dunlop

26700 Towne Centre Dr Suite # 270
Foothill Ranch, CA 92610

Phone: 949 668 0686

CONFIDENTIAL

New Patient Dental & medical history

Welcome to Treehouse Pediatric Dentistry! We are excited to meet you and so thrilled you've chosen us to care for your family's health!

Email: DrNasem@treehousepediatricdentist.com

TreehousePediatricDentist.com

Patient's Name: _____
Last First MI Preferred Name

Address: _____
Street Apt # City State Zip

Gender: ☐ Male ☐ Female Age: _____ Date of Birth: _____ SSN: _____

Father's Information:

Name: _____
Last First

Phone: _____

Date of Birth: _____

Email: _____

Employer: _____

Occupation: _____

Mother's Information:

Name: _____
Last First

Phone: _____

Date of Birth: _____

Email: _____

Employer: _____

Occupation: _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Who has legal custody of the child (if applicable): ☐ Mother ☐ Father ☐ Joint ☐ Other ☐ N/A

Is the patient a foster child? (if applicable): ☐ Mother ☐ Father *If yes, please provide court documents*

Please list other children in the Family:

Full Name	Relationship	Age	Date of Birth

Emergency Contact Person: _____
Name: Relationship: Phone #:

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Who can we thank for your referral? How did you hear about us? :

- ☐ Dental office _____
- ☐ Physician _____
- ☐ School or Daycare _____
- ☐ Insurance _____
- ☐ Family/Friend _____
- ☐ Yelp _____
- ☐ Google/Internet _____
- ☐ Outside Event _____
- ☐ Direct Mail _____
- ☐ Building Sign _____

Social Media or Other: _____

Dental Insurance Information

Does your child have dental insurance? ☐ Yes ☐ No

Name: _____

Last: First: MI: Relationship to Patient:

SSN: _____ Driver's License #: _____ Date of Birth: _____

Employer: _____ Address: _____

Dental Insurance: _____ ID#: _____ Group#: _____

Medical Insurance: _____ ID#: _____ Group#: _____

Secondary Insurance Information: *Complete if child is covered by another company*

Name: _____

Last: First: MI: Relationship to Patient:

SSN: _____ Driver's License #: _____ Date of Birth: _____

Employer: _____ Address: _____

Dental Insurance: _____ ID#: _____ Group#: _____

Financial Responsibility For Services

I hereby assign directly to Treehouse Pediatric Dentistry all dental benefits, if any, otherwise payable to me for services rendered to my child. I authorize to affix my name and validate "signature on file" to all claims and documents related to any health benefits and release any information necessary to bill my child's insurance carrier. I understand that I am financially responsible for any charges not covered by my child's insurance and that my portion is due and payable at the time services are rendered unless other arrangements have been made. I understand that any account balance over 30 days will be charged 1.5% interest per month, and/or late fees and service charges where applicable. I agree to pay all costs of collection including but not limited to court costs, commissions and costs of collection agency and reasonable attorney fees.

Signature of responsible party: _____ SSN: _____

Date of Birth: _____ Relation to Patient: _____

Name of responsible party: _____ Date: _____

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Medical History

Child's Physician: _____ Phone #: _____

Address: _____ Date of last Physician Exam: _____

			Please specify (Y/N Issues)
Is your child in good health?	☐ Yes	☐ No	
Has patient ever had health problems/been hospitalized?	☐ Yes	☐ No	_____
Is your child currently taking medications?	☐ Yes	☐ No	_____
Have you ever been told that child needs antibiotics before dental treatments ?	☐ Yes	☐ No	_____
Does your child have any food allergies?	☐ Yes	☐ No	_____
Does your child have any allergies to medications?	☐ Yes	☐ No	_____
Is your child allergic to latex?	☐ Yes	☐ No	_____
Does your child have any other allergies?	☐ Yes	☐ No	_____

Does your child have or has had ever of the following conditions?

ADD/ADHD:	☐ Yes	☐ No	GI Disorder:	☐ Yes	☐ No	Snoring:	☐ Yes	☐ No
Anemia:	☐ Yes	☐ No	Growth Problems:	☐ Yes	☐ No	Speech Problems:	☐ Yes	☐ No
Anxiety/ Nervousness:	☐ Yes	☐ No	Hearing Problems:	☐ Yes	☐ No	Tuberculosis:	☐ Yes	☐ No
Asthma:	☐ Yes	☐ No	Heart Disorder:	☐ Yes	☐ No			
Autism Spectrum:	☐ Yes	☐ No	Hepatitis:	☐ Yes	☐ No			
Behavior Issues:	☐ Yes	☐ No	HIV Infection:	☐ Yes	☐ No	Other (please specify)		
Brain injury:	☐ Yes	☐ No	Kidney Disease:	☐ Yes	☐ No	_____		
Cancer/ Tumors:	☐ Yes	☐ No	Learning Disability:	☐ Yes	☐ No	_____		
Cerebral Palsy:	☐ Yes	☐ No	Liver Disease:	☐ Yes	☐ No	_____		
Cleft Lip/ Palate:	☐ Yes	☐ No	Neuromuscular Defect:	☐ Yes	☐ No	_____		
Developmental Delay:	☐ Yes	☐ No	Orthopedic Problems:	☐ Yes	☐ No	_____		
Diabetes:	☐ Yes	☐ No	Psychiatric Disorder:	☐ Yes	☐ No	_____		
Eating Problems:	☐ Yes	☐ No	Rheumatic Fever:	☐ Yes	☐ No	_____		
Emotional Disability:	☐ Yes	☐ No	Seizures:	☐ Yes	☐ No	_____		
Fainting/Headaches:	☐ Yes	☐ No	Sleep Apnea:	☐ Yes	☐ No	_____		
Gag Reflex:	☐ Yes	☐ No						

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Dental History

Is this your child's first visit to the dentist? ☐ Yes ☐ No If no, when was the last _____ Were X-Ray's taken? ☐ Yes ☐ No

Name of previous dentist? _____ Phone # _____

Please describe patients dental problems if any? _____

_____

Please check any of the following that may describe your child's attitude towards dentistry?

☐ Cooperative ☐ Friendly ☐ Anxious ☐ Shy ☐ Uncooperative

Does your child have any of the following habits?

Nursing/Bottle	☐ Yes	☐ No	Teeth Grinding	☐ Yes	☐ No
Nail Biting	☐ Yes	☐ No	Cheek/lip biting	☐ Yes	☐ No
Thumb/Finger sucking	☐ Yes	☐ No	Jaw Clenching	☐ Yes	☐ No
Pacifier sucking	☐ Yes	☐ No	Mouth Breathing	☐ Yes	☐ No

Other (please specify) _____

Has your child had any unhappy dental experiences?	☐ Yes	☐ No	If yes, were there any problems?
Has the patient had local anesthesia?	☐ Yes	☐ No	_____
Does the child brush his/her own teeth?	☐ Yes	☐ No	_____
Do you assist in brushing your child's teeth?	☐ Yes	☐ No	Please specify if flouride use
Does your child use dental floss?	☐ Yes	☐ No	☐ Tablets ☐ Drops ☐ Water ☐ Gel/Paste ☐ Rinse
Does your child use fluoride in any form?	☐ Yes	☐ No	
Does your child have sugar snacks?	☐ Yes	☐ No	If yes how often ? _____ Per Day
Does your child drink sods and/ or juice?	☐ Yes	☐ No	If yes how often ? _____ Per Day

Is there anything else we should be aware of regarding your child's dental health?

_____

Consent For Services

I am the parent, guardian, or authorized caregiver for the patient and there are no court orders now in effect that limits me from signing this consent. I understand that the information I have given is correct to the best of my knowledge, that it will be held with confidentiality. It is my responsibility to inform the dental staff of any changes in my child's health status. I hereby authorize Dr. Nasem Dunlop and her associates to perform and necessary dental services including but not limited to comprehensive examination, taking dental x-rays, photographs or any diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs, cleanings, any recommended dental treatment mutually agreed upon and the use of appropriate medication, therapy and administration of anesthetic agent indicated for such treatment.

INITIAL _____

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Notice of Privacy and Practices Acknowledgement Form

I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Nasem Dunlop and her associates will provide an environment that will help children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments using variable vocal tonalities.

INITIAL _____

By signing below, you consent to the use and disclosure of your child's Protected Health Information (PHI) by Dr. Nasem Dunlop, her associates, and staff for treatment, payment and health care operations as specified on our Notice of Privacy Practices Form. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change and the revise Notice will be posted in our office. It may also be requested by contacting this office at (949)668-0686.
You have the right to request that we restrict our uses or disclosures of your child's Protected Health Information that we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding to us. You may refuse to consent to the use or disclosure of your child's PHI, but a written document is required. Under this law, we have the right to refuse services should you choose to refuse to disclose your child's Protected Health Information (PHI).

INITIAL

- ☐ I have reviewed, understood and AGREE to the consent of the Notice of Privacy Practice _____
- ☐ I have reviewed, understood and DISAGREE to the consent of the Notice of Privacy Practice _____
- ☐ I refuse to sign the Consent/Acknowledgement of Notice of Privacy Practice _____
- ☐ I acknowledge that a copy of Notice and Privacy Practice was provided and/or recieved _____

Print Name: _____ Date: _____

Signature: _____

Please specify a detailed reason why you disagree and refuse to sign the Consent/Acknowledgement of Notice of Privacy Practice:

_____

_____

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Appointment Policy

Our office shares the same priorities for your child's well being. We make an effort to schedule appointments for your child's best interest. Dental appointments are an excused absence. Missing school can be kept to a minimum when regular dental care is continued.

Late Policy

Please understand, for a typical 30 minute appointment, tardiness of even 10 minutes can greatly diminish the time and quality care your child should receive. Please understand that if you are more than 10 minutes late, your child's appointment might be rescheduled to another day, where we can allow enough time for his/her visit.

Appointments for siblings

We understand your time is very valuable. We can offer appointments for up to 3 siblings from the same family to come in together for their regular check up appointments. Please understand that we reserve over 1.5 hours for your family. If you break this type of appointment, any future scheduling will be for only 2 children at a time. The same tardiness and broken appointment policy applies for sibling appointments.

Failed Appointments

Since scheduled appointments are reserved exclusively for each patient, we ask that you please notify our office at least 24 hours in advance if you are unable to keep your regular check-up or consultation appointment. If your child is scheduled for dental treatment, especially under sedation or general anesthesia, our office requires a 48-hour notice if you cannot keep your appointment. Another patient who needs our care could be scheduled if we have sufficient time to notify them. We understand that unexpected things can happen, but we ask for your assistance in this regard.

Our failed appointment policy is as follows:

First failed appointment: $25 Broken Appointment Fee

Second failed appointment: $50 Broken Appointment Fee per patient and/or under Dr. Nasem's discretion, dismissal from practice

This is NOT in any way an attempt to punish a patient for unexpected emergencies (i.e. sudden illness, accidents). The fees listed above do not apply to these unforeseen circumstances, unless they are an ongoing issue. **If an appointment cannot be kept, please call us at least 24 hours before your appointment to cancel.**

We strive to offer the very best quality care and attentiveness to your child at each visit. We appreciate your cooperation and understanding.

I have read and understood the Appointment Policies mentioned above and agree to abide by the fee structure as per necessary.

Print Name: _____ Date: _____

Signature: _____