Welcome to Pediatric Dentistry of Los Altos

731 Altos Oaks Drive, Los Altos, CA 94024
(650) 948-6884
Thank You for Selecting Us

Child's Name: _____ DOB: _____

Nickname: _____ Age: _____ Gender: Male Female

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Mother/Guardian)

Name: _____ Relationship: _____
Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widow/er _____ Other _____

DOB: _____ Social Security #: _____ Email Address: _____

Home Address (if different than child): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN INFORMATION (Father/Mother/Guardian)

Name: _____ Relationship: _____
Marital Status: Single _____ Married _____ Separated _____ Divorced _____ Widow/er _____ Other _____

DOB: _____ Social Security #: _____ Email Address: _____

Home Address (if different than child): _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Occupation: _____

Other family members seen in this office _____

Please verify with your insurance provider as we are out of network with most insurance companies. Depending on your insurance provider, payment may be due in full at the time of service.

Primary Dental Insurance

Insured's Name: _____ DOB: _____

Relationship to Patient: _____ Social Security #: _____

Employer: _____

Subscriber's ID: _____ Group #: _____

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Secondary Dental Insurance

Insured's Name: _____ DOB: _____

Relationship to Patient: _____ Social Security #: _____

Employer: _____

Subscriber's ID: _____ Group #: _____

Insurance Company: _____ Phone #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip Code: _____

Who can we thank for referring you to us? (please check all that apply)

□ Primary Care Doctor _____ □ Friend/Family _____

□ Internet _____ □ School/Daycare _____

□ Insurance Company _____ □ Other _____

Dental History

Is this your child's first dental/ortho visit? Yes _____ No _____ If no, please complete the following information:

Previous dentist's name: _____ City/State _____ Phone _____

Has your child had an unfavorable experience in a dental or medical office? Yes _____ No _____

If yes, please explain: _____

Have there been any injuries to your child's teeth or jaws – blows, chips, etc? Yes _____ No _____

If yes, please explain: _____

Does your child complain of, or show any evidence of jaw joint problems (Pain, problem opening) ? Yes ___ No ____

Does your child, or any family member have a history of missing or extra teeth? Yes _____ No _____

Does your child receive fluoride vitamins, tablets, or water? Yes _____ (if yes circle which one) No _____

Has your child had a toothache recently? Yes ___ No _____ If yes, specify area: _____

Does your child have a thumb sucking, lip sucking, nail biting, nursing bottle or pacifier habit? Yes _____ No _____

If yes, please circle which habit(s) or list other habits: _____

Medical History

Name of child's physician: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Is your child presently under the care of a physician for any medical problem or condition, or is surgery pending? Yes ___ No ____ If yes, please specify: _____

Is your child allergic, or had any reaction to any food, medicine, local anesthetic, or antibiotic? Yes ___ No ___

If yes, please explain: _____

Does your child have any symptoms or been diagnosed for:

Heart Murmur or other heart condition	Yes___ No___	Rheumatic Fever	Yes___ No___
Diabetes	Yes___ No___	Asthma	Yes___ No___
Cerebral Palsy	Yes___ No___	Hepatitis	Yes___ No___
Kidney or liver involvement	Yes___ No___	Bleeding Disorders	Yes___ No___
Blood transfusions	Yes___ No___	ADD/ADHD	Yes___ No___
Seizures or convulsions	Yes___ No___	Latex Allergy	Yes___ No___
Peanut/Nut Allergy	Yes___ No___	Epilepsy	Yes___ No___
Tuberculosis	Yes___ No___	Autism	Yes___ No___

Has your child had any diagnosis of immunological problems? Yes ___ No ___ If yes, please specify: _____

Please list any medications your child is currently taking:

Medication: _____ Reason: _____

Please list any hospitalizations or surgeries your child has had: _____

Reason: _____ When: _____

Please list any special needs, handicaps, or disabilities we should be aware of: _____

_____

Because conditions in the mouth can be hereditary, it is important to know if your child is adopted? Yes ___ No ___ If yes, does he/she know? Yes ___ No ____

Please list any other medical information or problem you feel should be brought to the doctor's attention: _____

I have read and noted patient's health history.

Doctor's signature _____ Date _____

Authorization: I hereby authorize the doctors of Pediatric Dentistry of Los Altos to obtain further information on any health question, and I understand that it is my responsibility to keep this practice informed of any changes to the medical history or condition of the patient. I understand that a charge will automatically be applied to my account for broken appointments unless 48 hour notice is given. A parent or legal guardian must accompany the patient for the initial appointment. My signature below indicates that I have completed this form and that the individual named on the front of this form authorized to accompany the child to Pediatric Dentistry of Los Altos.

Signature of Parent or Legal Guardian _____ Date _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.

- _____ _____

Signature of Insured **Date**

We look forward to caring for your child!

Nick Gorgani, D.D.S., M.S.
Cynthia Yee, D.D.S., M.S.

Shiva Sheikholeslam, DMS, MDS
Karin Chima, DMD, MMSc

PEDIATRIC DENTISTRY OF LOS ALTOS
731 Alto Oaks Drive, Los Altos, CA 94024

INFORMED CONSENT

Our pediatric dental office philosophy is based on our commitment to preventative dentistry and to creating a supportive and nurturing environment for the children and young adults under our dental care. In particular, we are dedicated to providing safe, comfortable and quality dental treatment for all of our patients.

California State Law requires us to obtain your informed consent before we can provide any dental services for your child. Our most important general office policy is to "inform before we perform". Specifically, we are requesting your permission for the following diagnostic and preventive dental procedures: comprehensive clinical examination, selected diagnostic x-ray, thorough professional cleaning and decay-fighting fluoride treatment.

If dental treatment is necessary, we require your consent for a number of additional procedures which include, but not limited to, the following: local anesthesia ("novocaine" or "sleepy juice"), low-level nitrous oxide-oxygen sedation ("space gas" or "laughing gas"), comfortable mouth prop ("tooth pillow" and extensive use of the classic "tell-show-do" method of introducing new methods and materials to your child. Unless specifically invited by the doctors, parents and other caretakers are requested to remain in our reception area during your child's dental appointment.

Please feel free to ask us any questions you may have regarding the preceding information or concerning any other aspect of our dental practice. Additionally, you may wish to discuss our policies with other individuals who are involved in caring for your child.

Therefore, I hereby give my consent to the dentists of Pediatric Dentistry of Los Altos, to provide mutually agreed upon dental services for my child. I am aware that the dentists are specialists in pediatric dentistry. I further agree that this consent shall remain in full force unless withdrawn in writing by the person who has signed below on behalf of the minor patient or themselves.

Thank you for taking the time to read and sign this important document.

PRINT PATIENT'S NAME	YOUR SIGNATURE
PATIENT'S AGE	PRINT YOUR NAME
WITNESS' SIGNATURE	YOUR RELATIONSHIP TO PATIENT
PRINT WITNESS' NAME	TODAY'S DATE

PEDIATRIC DENTISTRY OF LOS ALTOS
731 Alto Oaks Drive, Los Altos, CA 94024

PAYMENT POLICY

We appreciate you choosing Pediatric Dentistry of Los Altos for your child's dental care. At Pediatric Dentistry we value our relationship with your family and would like to offer the following as our payment policy:

- For patients without insurance we do ask for payment in full at the time of the visit.

- In case of insurance, we will be happy to help you receive the maximum benefits available under your policy. However, please realize that the relationship is between you, the insured, and your insurance company. If insurance is pending, you will receive an interim statement to let you know that he account has not been paid. If we do not receive payment from your insurance company within six weeks after submission of the claim, you will be expected to pay for all dental services in full. In the event of duplicate payments, you will be reimbursed.

- A finance charge will be added to your account on any balance not paid in full within 60 days from date of service. If your account should be sent to collections a $25.00 delinquency fee will be added to your balance.

- Once treatment and the estimated insurance benefits are reviewed with you, we require that you pay your portion at the time of service.

- For your convenience we accept cash, check, Visa, Master Card, and American Express.

- Please note that the parent or guardian bringing in the child into the office on the day of service will be expected to pay for services rendered.

- A finance will accrue on all accounts 60 days past due.

- A cancellation or change should be made at least 48 hours in advance. It is our policy to charge for a broken appointment. There will be a $25.00 charge for any returned checks.

I have read and understand the payment policies for the office:

Patient's Name (print) _____
Parent's Name (print) _____
Parent's Signature _____
Date _____

PEDIATRIC DENTISTRY OF LOS ALTOS
731 Alto Oaks Drive, Los Altos, CA 94024

OFFICE POLICIES

In order for our doctors and staff to fully accommodate our patients and their families Pediatric Dentistry of Los Altos has formed the following policies:

1. All children age 6 and under will be seen in the morning. This is to benefit the child. The child is not tired from a full day of activities, school, etc. This keeps the experience positive for the child. Parents are invited back with the child(ren) in the morning.

   At age 7 and older, if the child is cooperative, children may come for appointments in the afternoon. Parents are asked to remain in the waiting room during these appointments. Once the appointment has been completed, parents are asked to come into the operatory to speak with the doctor.

2. All Special needs patients, regardless of age, are seen in the morning. This allows the doctor to give the child the extra time and special care they need.

3. A parent or guardian MUST accompany all new patients for the first visit.

4. The parent bringing in the child(ren) is responsible for all charges.

5. After each visit, our business office will file your insurance claims for you as a COURTESY. You are responsible for all charges incurred.

6. A finance charge will accrue on all accounts 60 days past due.

7. A CHARGE WILL AUTOMATICALLY BE APPLIED TO YOUR ACCOUNT FOR BROKEN APPOINTMENTS UNLESS 48 HOURS NOTICE IS GIVEN. YOU ARE RESPONSIBLE FOR MAKING AND KEEPING YOUR APPOINTMENTS.