Temecula Kids Dental Care

Dear Parents and Guardians,

We would like to welcome you and your children to our dental practice. In order for your child to receive the best possible dental care with a pleasant office experience, we have established after many years of experience in this filed the following office policies: Parents or guardian are welcome to accompany their children into the operatory room during examination and cleaning procedures. We request that during the taking of x-rays on your child that you step outside of the room upon completion of the x-rays you are welcome to return. Parents or guardian are also welcome to accompany their children into the operatory room during dental treatment as long as the child cooperates with the dentist while the parent is present. We use nitrous oxide gas to relax children if necessary to assist the dentist in completing dental treatment. We have also worked out a system of hand signals from your child to the dentist to let him know when the child is experiencing any discomfort. Most children cooperate with the dentist while their parents are in the room, but should your child become upset or difficult to control we ask that you step out of the room in order for the dentist to regain your child's trust and complete your child's treatment. We have found that some children cooperate better with the dentist if they are not trying to win sympathy from their parents in the room. If the dentist feels that your child is too upset, rather than trying to force dental treatment, our dentist may suggest general anesthesia. The dentist may also feel that it would be better for your child to be referred out for hospital dentistry where your child can be sedated under general anesthesia to complete dental treatment. Dr. Baker has been a very successful pediatric dentist for almost 20 years with an endless list of satisfied patients. Our entire staff is professional who strive to do their very best at all times. Our primary goal in treating any child is to put their health and safety first and foremost during any dental treatment. Thank you for choosing our office.

Dr. Fattouch & Staff

Patients Name: _____

Parent/Guardian Signature: _____ Date: _____

Insurance Payment Release Form

Patients Name: _____

Subscriber Name: _____

Subscriber ID: _____

Insurance Company: _____

I, _____ hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the rendering dental provider.

I have been informed of the treatment plan and associated fees, I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by the 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, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Print Name: _____

Signature: _____ Date: _____

Dear Parents,

We would like to welcome you and your children to our dental office. We gladly accept most insurance policies, however due to a change in our policy; our office is currently collecting patients' co-pays based on our usual and customary fees.

After a claim has been submitted to insurance and received by our claims department, if an overcharge has occurred we will gladly compensate the difference of amount. We appreciate your understanding and full cooperation regarding this matter.

Patients Name: _____

Date: _____

Parents/Guardians Signature: _____

Cancellation Policy

We take great pride in seeing everyone with an appointment in a timely manner. We believe that your time is as valuable as our own. If you are unable to keep your appointment, please give us a 24 hour notice so that someone else needing our services may be seen at that time. We will be happy to re-schedule your appointment for a future date and time. I understand that failure to cancel or reschedule an appointment without a 24 hour notice will result in a broken appointment charge of $25.00

Parent/Guardian Signature: _____ Date: _____

RESPONSIBILITY AND CONSENT STATEMENT

I hereby authorize and request the performance of dental services for my children:

Patient Name: _____ Age: _____

Patient Name: _____ Age: _____

Patient Name: _____ Age: _____

Patient Name: _____ Age: _____

I also give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for the diagnostic purposes or dental treatment. I understand and acknowledge that I am financially responsible for the services provided for myself or the above named, regardless of insurance coverage.

Parent/Guardian Signature: _____ Date: _____

INFORMED CONSENT FORM FOR DENTAL TREATMENT

FILLINGS

Benefits:

- Eliminates decay
- To relieve pain
- Fill in a whole or space in a tooth
- Cover eroded areas
- Protect a sensitive surface

Possible Complications:

- Tooth may abscess from the filling
- May fracture tooth
- Tooth may be sensitive to temperature changes
- Toxicity from the silver filling is alleged by some
- Fillings may fall out

Consequences of not having or postponing treatment:

- Tooth may become unsalvageable
- Tooth may fracture
- Decay will increase
- Pain will get worse
- May result in need for a root canal

Alternatives

- Temporary filling
- Extraction

X-RAYS

Benefits:

To obtain a complete diagnosis
Find hidden problems
X-rays are taken by qualified personnel
Help determine treatment options

Possible Complications:

Exposure to minimal x-ray radiation
X-ray pictures remain the property of the dental office

Consequences for not taking x-rays:
Cannot perform dental services/Alternatives: NONE

Cleaning/Scaling

Benefits
Clean Mouth
Eliminates Odor
Prevents gum disease
Some portions maybe performed by auxiliary personnel

Possible Complications:

Sensitivity
Filling maybe loosened

Sensitive Gums

EXTRACTIONS

Benefits:

- Last resort for an unsalvageable tooth
- Eliminates pain
- Remove teeth that are out of position
- Eliminates infection

Possible Complications:

- Fractures particles may retain
- Irritation to nerves may cause temporary or permeant numbness
- Part or the entire tooth maybe lodged in the sinuses requiring more surgery
- Bad infections may take a longer time to clean up
- Jaw maybe stiff and difficult to open for some time
- If the jaw bone is weak it can fracture

Consequences of not having or postponing treatment:

- Spread of infection
- Swelling
- Pain
- Fever

Consequences of not having or postponing treatment

Stains on teeth

Odors
Gum Disease
Premature loss of teeth
Alternatives: NONE

BONDED FACING

Benefits:
Aesthetics- Teeth look nicer
Cover crooked teeth
Close spaces and gaps
Cover discolored teeth
Possible Complications:

Edges can stain after time

breakage can occur
Difficult to remove
Just for cosmetic reasons

LOCAL ANESTHETICS

Benefits:

- Avoid pain or discomfort during treatment

Possible Complications:

- Prolonged numbness
- Nerve damage
- Bruising
- Rare circumstances include all those applicable to general reactions up to and including death

Consequences of not having or postponing treatment:

- Possible mild to severe pain during and after treatment

Alternatives:

- Willingness to endure possible mild to severe pain during treatment.

CROWNS (CAPS)

Benefits:

- Aesthetics
- To repair a tooth that is broken
- To prevent a tooth from fracture
- To eliminate a space where food is being trapped

Consequences of not having or postponing treatment:

- Possibility of the tooth fracturing
- Tooth may need to be extracted
- Tooth may need a baby root canal

Alternatives:

- Extraction
- Temporary crown
- Stainless steel crown

- To splint a loose tooth together to strengthen them
- If the tooth cannot be filled

Possible Complications:

- Porcelain portion of crown may fracture
- Crown may come off and need to be re-cemented
- Tooth may abscess and require further treatment
- Future decay may require a new crown

I have read the above statements and have received a copy of them. I recognize the importance of these statements in helping me make decisions regarding my child's dental needs. I recognize that failure can occur for various reasons and complications can occur in any procedure. I also understand that where decay was present, where a tooth was fractured or abscess there problems could still affect the tooth even after the tooth has been restored. In order to receive treatment I contract that if then is any indifferences or disagreements between my attending dentist and myself I will first present such indifferences or disagreements to my attending dentist in order to resolve the issue. If the attending dentist and I are unable to reach an agreement then I agree to take the problem to a reconciliation board, such as the Dental Society or California State Consumer Affairs Board of Dental Examiners. I agree to accept their resolution in lieu of pursuing remedies by way of litigation in consideration of helping keep the cost of treatment and services as low as possible. I also understand that this agreement is binding on my heirs and all other family members.

Name of Patient(s): _____

Parent Name: _____

Signature: _____ Date: _____

Guardian Information

Patient Name(s):

_____

Guardians Name(s): _____

Guardians DOB: _____ Guardians SSN: _____

Guardians Current Address: _____

_____

_____

NO PO BOX, PLEASE

Guardians Contact Home #: _____

Cell #: _____

Guardian's relationship to child: ( ) Mother ( ) Father ( ) Other: _____

Guardians Signature: _____ Date: _____

We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request appointments online
- Confirm appointments via Email
- Receive text message appointment reminders
- Submit patient satisfaction surveys
- Refer your friends online

You may opt-out of our communications at any time by clicking the unsubscribe link found in the footer of each email or by replaying to a text message with "STOP". Standard text messaging rates may apply.

PLEASE VERIFY YOUR CONTACT INFORMATION

Cell Phone: _____

_____ Check here to Opt-in to Text Messages

Email: _____

_____ Check here to Opt-in to Email

Parent Signature: _____ Date: _____

Establishment of Financial Responsibility

A representative from our front office staff will provide you with an estimate of your total charges prior to your child's visit. The estimate is based on the information that our office received when verifying active coverage and benefit information directly from your dental insurance carrier. The information obtained is in direct correlation with your contract specifics, however please note it is NOT a guarantee of payment. Once in-office services are rendered you will be asked to pay your deductible, co-pay, and/or co-insurance. As a courtesy, we will then bill your dental insurance company on your behalf. While each insurance company is different, we generally expect payment to be received within 60 days of claim submission. If payment is not received we will then send notification of their non-payment with a billing statement and request that you contact them directly. In the instance of non-payment, please note YOU will then be held financially responsible for any balance due. We ask that you claim full responsibility for knowing the specifics of your insurance contract. Examples of these specifics include but are not limited to: copays, deductibles, pre-authorizations, covered and non-covered services and policy maximums. If you have any questions regarding in-office insurance verification, the claim submission process or your financial responsibilities please let our front office staff knows so we may further assist you.

Parent Signature: _____ Date: _____