

WELCOME

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ SS/HIC/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex M F Age _____
 Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Cell Phone (____) _____

Home Address _____
 Street City State Zip

Mailing Address _____
 Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above) E-mail _____ Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (____) _____ Address _____ Group # _____ Policy # _____ Is your child eligible for treatment under Medical Assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No Child's Medical Assistance I.D. # _____	Mother's/Guardian's Name _____ Address (if different from patient's) _____ _____ Home Phone (____) _____ Work Phone (____) _____ (if different from above) (if different from above) E-mail _____ Employer _____ Soc. Sec. # _____ Birthdate _____ Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Plan Name _____ Phone (____) _____ Address _____ Group # _____ Policy # _____
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DENTAL HISTORY

Date of last visit to a dentist _____ YES NO Has child complained about dental problems? <input type="checkbox"/> <input type="checkbox"/> Does child brush teeth daily? <input type="checkbox"/> <input type="checkbox"/> Does child use floss every day? <input type="checkbox"/> <input type="checkbox"/> Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? <input type="checkbox"/> <input type="checkbox"/>	For what service? _____ YES NO Is fluoride taken in any form? <input type="checkbox"/> <input type="checkbox"/> Any injuries to mouth, teeth, head? <input type="checkbox"/> <input type="checkbox"/> Any unhappy dental experiences? <input type="checkbox"/> <input type="checkbox"/>
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MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

Is Minor/Child under care of physician now? YES NO
 Medications _____

Receiving any medication or drugs? _____

Ever been hospitalized? _____

Ever had surgery? Allergies _____

Is there excessive bleeding when cut? _____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> A.I.D.S./H.I.V. | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Fainting | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Measles | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Drug/Alcohol Abuse | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Other |

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child

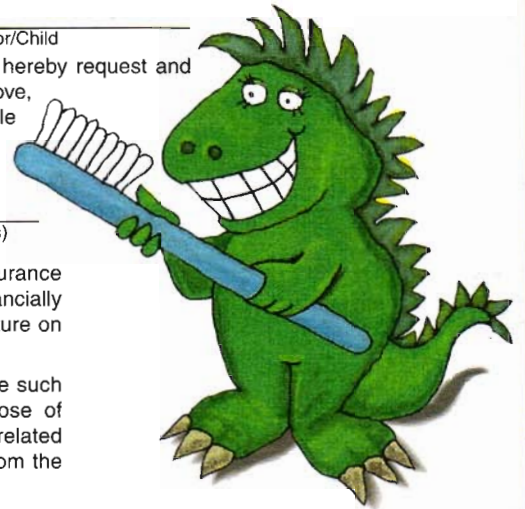
and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____
Name of Insurance Company(ies)

and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.



Signature of Parent, Guardian or Personal Representative

Date

Please print name of Parent, Guardian or Personal Representative

Relationship to Patient

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? Yes No

If yes, please describe _____

Is patient taking any new medications? Yes No If yes, please list _____

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

UPDATE

CONSENT FOR TREATMENT

1. I hereby authorize Doctor _____, or designated staff, to take x-rays, study models, photographs, and/or use of any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of _____'s (name of patient) dental needs.
2. Upon such diagnosis, I authorize Doctor to perform all recommended treatment mutually agreed upon by me and Doctor and to employ such assistance as required to provide proper care.
3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at time of service unless other arrangements have been made. In event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account.

PATIENT: _____

DATE: _____

PARENT OR RESPONSIBLE PARTY: _____

RELATIONSHIP TO PATIENT: _____

Michael E. Huguet, D.D.S.
Jill K. Owens, D.D.S.
Family and Cosmetic Dentistry

710 Grayson Road
Pleasant Hill, CA 94523
Phone (925) 945-6204 Fax (925) 945-1533

FINANCIAL POLICY

We appreciate your selection of this office to serve your dental health needs. Our goal is to provide you the best possible dental care. We want you to enjoy optimal dental health throughout your life. In order to extend comprehensive care to our patients and avoid misunderstanding, we have outlined below our financial policies.

PAYMENT OPTIONS

It is customary to receive full payment for your dental care at the time service is rendered. For your convenience we offer one of the following payment options:

1. Cash or Check (If you pay in full prior to your treatment you will receive a 5% billing discount).
2. Major Credit Card (If you pay in full prior to your treatment you will receive a 3% billing discount).
3. Extended Payment Plan (Please arrange this with the office staff prior to beginning treatment).

Please let us know your payment preference prior to receiving dental services so we may properly prepare your treatment plan. Our staff is here to assist you if you have any questions.

FEE CHANGES

We will provide you an estimate of your fees prior to the Doctor performing any services. It is not, however, possible to determine the full extent of all necessary treatment prior to the Doctor performing some services. Thus, your treatment needs and fees may need to be modified once we begin treatment. Should the Doctor determine that any additional or different services are necessary he/she will inform you of any changes in treatment or fees.

DENTAL INSURANCE

Your dental insurance is an agreement between you and your carrier. We will be happy to assist you by submitting all necessary insurance forms to your carrier. Please remember however that you are directly responsible to us for the obligation of payment for treatment regardless of the amount paid by your insurance carrier. While we will do our utmost to help you derive the maximum benefits to which you are entitled, it is your responsibility to track the yearly maximum benefits available under your policy.

Most insurance companies cover basic services and pay only a part of the total cost of dental services. Cosmetic services and some types of tooth colored restorations are often not covered. Our experience has shown that the various policies cover from 25% to 100% of the fees. It is our policy to ask for the percentage not covered by your policy at the time of treatment for basic and major dental work.

RESCHEDULING APPOINTMENTS

If it is necessary to reschedule an appointment, we would appreciate at least 48 hours notice so we can offer that time to another patient. A reasonable fee will be charged for each hour scheduled for a failed appointment if a 48-hour courtesy notice is not given.

FINANCE CHARGE

Any account balance over 90 days old will be subject to a 1.5% per month (18% annually) finance charge.

I have reviewed the above policy and I understand the procedures set forth in this document.

Signature

Date

Patient Name-Last, first

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet

Dear Patients,

In an effort to better inform dental consumers, The Dental Board of California has provided all licensed dentists an updated Material Fact Sheet to be distributed to all new and returning patients. You are being provided a copy at this time, which summarizes information on materials most frequently used for dental care. Please save your copy and review at your convenience. As always, we are here to answer any questions you may have as to which restorative option is best for you.

I acknowledge that I have received a copy of the Dental Material Fact Sheet as required by state law from the office of Drs. Huguet, Oweris, and Barpal.

Patient Signature

Date

I acknowledge receipt for the following minors and the need to keep this list updated:

_____ Minor's Name	_____ Age	_____ Birthday-MM/DD/YY	_____ Relationship-Parent/Guardian
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_____ Minor's Name	_____ Age	_____ Birthday-MM/DD/YY	_____ Relationship-Parent/Guardian
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_____ Minor's Name	_____ Age	_____ Birthday-MM/DD/YY	_____ Relationship-Parent/Guardian
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_____ Minor's Name	_____ Age	_____ Birthday-MM/DD/YY	_____ Relationship-Parent/Guardian
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_____ Minor's Name	_____ Age	_____ Birthday-MM/DD/YY	_____ Relationship-Parent/Guardian
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Parent/ Guardian Signature

Date

**MICHAEL E. HUGUET, D.D.S.
AND ASSOCIATES**

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I, _____, acknowledge that I have received a copy of the Notice of Privacy Practices from the above named office.

Please Print Name (Patient)

Signature

Date

Personal Representative

Relationship to Individual

For Office Use Only

I acknowledge that I attempted to obtain from the above patient a written acknowledgment of their receipt of our Notice of Privacy Practices but the acknowledgement could not be obtained because:

I attest that the above information is correct.

Employee Name

Date