Welcome!

Natalie A. Lenser, D.D.S
3109 Coffee Road, Suite B, Modesto, CA 95355, 209/571-7283, Fax / 571-7285

Patient ID #_____ Policy Holder ID #_____ Responsible Party #_____

Name of Minor/Child_____
Last Name First Name Middle Initial

Sex: Male ____ Female____ Birthday_____ Nickname_____ Hobbies_____

Childs Home Address_____
Street City State Zip

Mailing Address_____
(if different) Street City State Zip

Who is accompanying the child today? Name_____ Relationship_____

Phone Home:_____ Cell:_____ Mom or Dad Marital Status: Single ____ Married ___ Divorced___ Widowed___

Email Address:_____

In the event of an emergency, whom should we contact? Someone other than Parent/Legal Guardian.

Name:_____Relationship_____Phone_____

Whom may we thank for referring you?_____

Father's/Guardian's Name_____

Address _____

_____

Phone: Home_____ Work#_____
(If different from above)

Soc. Sec.#_____Birthdate_____

Employer_____

Do you carry dental insurance coverage for your child? Yes No

Insurance_____

Phone No._____

Address_____

Group # (Plan, Local or Policy)_____

Mother's/Guardian's Name_____

Address _____

_____

Phone: Home_____ Work #_____
(If different from above)

Soc. Sec.#_____ Birthdate_____

Employer_____

Do you carry dental insurance coverage for your child? Yes No

Insurance_____

Phone No._____

Address_____

Group # (Plan, Local or Policy)_____

FINANCIAL AGREEMENT, ASSIGNMENT OF BENEFITS AND AUTHORIZATION FOR TREATMENT: I request and authorize treatment of the person named above and agree, irrevocably, whether signing as agent or as patient, that in consideration of the services to be rendered to the patient that I hereby individually obligate myself to pay the account in accordance with the regular rates and terms of the provider. I hereby give authorization for payment of the insurance benefits directly to provider named above, and any assisting physicians for services rendered. As required by law, you are hereby notified that a negative credit report reflecting on your credit record may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations. Should the account be referred to an attorney or collection agency for collection, the undersigned agrees to pay actual attorney's fees and collection expenses. It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pendency of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without their assuming responsibility for the collection thereof. (A copy of this assignment is as valid as the original). Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. A $25.00 fee is charged on all returned checks. A $25.00 service charge will be assessed on all accounts not settled within each 30-day cycle after determination of patient responsibility. In addition to cash or check, Visa , Master Card, American Express and Care Credit are accepted. RELEASE OF INFORMATION: The provider may disclose all or part of the patient's record to any person or corporation which is or may be liable under a contract to the provider or to the patient, family member, or the employer of the patient or the family member for all or part of the providers charge, including but not limited to, medical service companies, workman's compensation carriers, welfare funds, or the patient's employer. I further authorize my employer to release employment information to the provider or the provider's agents.

_____ _____
Signature Date

OVER →

Patient's **Full Name** _____ Age _____ DOB_____

Medical/Dental History

Date of last dental visit_____

Previous Dentist_____

Child's Physician_____

Physician's phone #_____

Pharmacy_____

For Office Use Only:

Pt Wt._____

Date_____

Int._____

P: UR LR UL LL DL CK_____

Medical History

Reason for today's visit_____

Is your child under the care of a physician now? Yes No Reason_____

Is your child taking medication daily? *If yes please list.* Yes No_____

Has your child ever taken medications including Bisphosphonates? (bone strengthener) Yes No_____

Does your child have any drug/food allergies? *Please List* **Yes No**_____

Does your child take liquid medication well? Yes No_____

Has your child ever been hospitalized? For what? Yes No_____

Has your child ever had surgery? When/What Yes No_____

Does your child have special needs? *If yes please list:* Yes No_____

Is your child taking fluoride supplements? Yes No_____

Any injuries to mouth, teeth, or head? Yes No_____

Does your child have any medical problems/conditions? Yes No_____

Please Explain_____

Has your child ever had any of the following? Please Circle All

Yes No ADD/ADHD	Yes No Diabetes	Yes No Kidney Disease	Yes No Premature Birth
Yes No A.I.D.S/HIV	Yes No Drug/Alcohol Abuse	Yes No Liver Disease	Yes No Seasonal Allergies
Yes No Asthma	Yes No Epilepsy/Seizures	Yes No Measles/Mumps	Yes No Lung Problems
Yes No Autism	Yes No Fainting	Yes No Mononucleosis	Yes No Blood Disease
Yes No Anemia	Yes No Hearing Problems	Yes No Sinus Problems	Yes No Latex Allergy
Yes No Bladder Problems	Yes No Heart Problems/Murmur	Yes No Rheumatic/Scarlet Fever	Yes No Excessive Bleeding
Yes No Cerebral Palsy	Yes No Congenital Heart Defect	Yes No Thyroid Disease	Yes No Snoring when sleeping
Yes No Chicken Pox	Yes No Hepatitis	Yes No Tuberculosis	Yes No Sleep Apnea
Yes No Hemophilia	Yes No Convulsions	Yes No Frequent Headaches	Yes No Metal Allergy
Yes No Hives/Rash	Yes No Pain in Jaw Joints	Yes No Tonsillitis	Yes No Grinding
Yes No Cancer	Yes No Cold Sores/Fever Blisters	Yes No Bed Wetting	

Dr. Lenser Comments_____

_____ **Dr. Initials**_____

Authorization for Release

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnoses and the records of any treatment or examination rendered to my child during the period of such dental care to third party payer and/or health practitioners.

_____ _____

Parent/Legal Guardian **Date**

Natalie A. Lenser D.D.S
3109 Coffee Road Suite B
Modesto, CA 95355
(209) 571-7283
(209)571-7285 FAX

Notice of Privacy Practices

This notice describes how your child's health information may be used and disclosed and how you can get access to this information. Please review it carefully. The privacy of your child's health information is important to us. This Notice is regarding:_____
(Patient's Name)

Our Legal Duty

Federal and state laws require us to maintain the privacy of your child's health information. We are also required to provide this Notice about our office's privacy practices, our legal duties, and your rights regarding your child's health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect _____ and will remain in effect until we replace it.
(Today's date)

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new notice available upon request. For more information about our privacy practices or additional copies of this Notice, please contact us (contact information at top of document).

Uses and Disclosures of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations.

For example:

Treatment:

We disclose medical information to our employees and others who are involved in providing the care your child needs. We may use or disclose your child's health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your child's health information with a pharmacist in order to provide you a prescription for your child, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment:

We may use and disclose your child's health information to obtain payment for services we provide; unless you requested that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations:

We may use and disclose your child's health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities.

Parent/Legal Guardian **Signature**_____

Natalie A. Lenser D.D.S
3109 Coffee Road Suite B
Modesto, CA 95355
(209) 571-7283
(209)571-7285 FAX

Acknowledgement of Receipt of Notice of Privacy Practices

****You may refuse to sign this acknowledgement****

I,_____the parent/legal guardian of_____
(Parent/legal guardian name) (Patient's name)
Have received a copy of Natalie A. Lenser D.D.S., Notice of Privacy Practices.

_____
[Print parent/legal guardian name]

_____
[Signature of parent/legal guardian]

_____
[Today's Date]

For Office Use Only

Patient Information:

Patient Name_____Chart #_____

*We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (Please Specify)

_____

Natalie A. Lenser, D.D.S.
DIPLOMATE OF THE AMERICAN BOARD OF PEDIATRIC DENTISTRY
3109 Coffee Road, Suite B
Modesto, CA 95355
(209) 571-7283 Fax (209) 571-7285

FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. It is our policy to make definite financial arrangements with you before any treatment starts. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards (Visa, MasterCard, American Express, and Care Credit). We will bill your insurance company as a courtesy to you. If you have Dental Insurance and your insurance company pays you directly, you will be considered a cash paying patient.

2. Dental insurance information must be provided at the time of service. This will include the name of the dental insurance, subscriber's social security number, date of birth, mailing address, phone, and group number. If insurance coverage cannot be verified you will be responsible for payment of all dental services rendered. Secondary insurance will be filed only if the correct information is provided at the time of service.

3. Dental benefit plans may cover only part of your dental treatment. It is understood that you are responsible for the entire balance of your account. The contract of dental benefits is between the patient and the insurance company. The fact that we do not write or administer your Dental Benefit play makes it impossible for us to assure any payment from a third party carrier for any parts of the above estimated treatment plan. You are responsible for all services rendered, regardless if you have dental benefits or not. We will bill your insurance as a courtesy to you.

4. Our office will make every reasonable effort to obtain payment from your insurance company. If the claim remains unpaid after 90 days, you will be responsible for the remaining balance. Your account will be assessed and additional $25.00 fee if collection services are required.

5. A fee of $50.00 will be charged for all failed appointments and appointments cancelled with less than 48 hours' notice. There will be a $25.00 charge for all returned checks.

6. The parent or guardian who brings the child for an initial visit is the responsible party. This parent is required to pay for services rendered regardless of what a divorce decree may state.

7. As a courtesy, our office will bill most dental insurance plans for you. However, dental insurance plans such as Covered California and Anthem/Blue Cross/Blue Shield, are insurances that we do **not** bill at this time. We will give you all necessary information at the time of your appointment to bill your insurance company.

8. As required by law, you are hereby notified that a negative credit report notation may be submitted to a credit reporting agency if you fail to fulfill the terms of your credit obligations. Should the account be referred to an attorney or collection agency, you agree to pay attorney and collection expenses.

AUTHORIZATION

1. I hereby give authorization for payment of insurance benefits directly to Natalie A. Lenser DDS for services rendered.
2. I hereby give authorization for our office to contact all phone numbers provided to us in collection of remaining balances.
3. I have read and accept the above Financial Policy, understand it, and agree to the terms set forth regarding payment for any and all dental services rendered.
4. By signing below, I hereby acknowledge and understand that I am financially responsible for the account.

_____ _____

Patient Name **Date**

_____ _____

Signature of Parent or Guardian **Print Name**