Dr. Raymond A. Ramos DDS
& Associates

Child's Name: _____ Gender: ☐ M ☐ F ☐ _____ Birthdate: ____/____/____

Parent's Information

Parent #1	Parent #2
☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ _____	☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. ☐ _____
Name: _____	Name: _____
Relationship to Child: _____	Relationship to Child: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Email: _____	Email: _____
Home Phone: (____) _____ Cell: (____) _____	Home Phone: (____) _____ Cell: (____) _____
Work Phone: (____) _____ Date of Birth: _____	Work Phone: (____) _____ Date of Birth: _____
Driver's License #: _____ State: _____	Driver's License #: _____ State: _____
Occupation: _____	Occupation: _____
Employer Name: _____	Employer Name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Parent's Dentist: _____	Parent's Dentist: _____

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

Child Lives With:
☐ Both Parents ☐ Parent 1 ☐ Parent 2 ☐ Step Parent ☐ Other

Insurance Information

PRIMARY INSURANCE	SECONDARY INSURANCE
Name of Insured: _____	Name of Insured: _____
Address (if different from above): _____	Address (if different from above): _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Date of Birth: ____/____/____	Date of Birth: ____/____/____
Social Security #: ____–____–____	Social Security #: ____–____–____
Insurance Company: _____	Insurance Company: _____
Address of Insurance Co. _____	Address of Insurance Co. _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Member ID#: _____	Member ID#: _____
Group or Plan Number: _____	Group or Plan Number: _____
Insurance Company Phone #: (____) _____	Insurance Company Phone #: (____) _____

Emergency Contact

Name: _____

Phone: _____ Relationship: _____

Who May We Thank for Referring You Today?

Name: _____

Financial Responsibility and Assignment of Benefits

Assignment of benefits: I hereby authorize payment directly to the above named dentist of the group dental benefits otherwise payable to me. I understand that I am financially responsible for 100% of all charges incurred regardless of any insurance benefits. I also understand that by signing this, I am the responsible party on this account.

Signature: _____ Date: _____

Social Security Number: _____

Authorization to Release Health Information

Authorization and Release: I authorize the dentist/dental staff to perform the necessary dental services that my child may need. I also authorize the dentist/dental staff to release any information, including diagnosis and/or x-rays rendered to my child during the period of such care to any third party payers and/or health providers. I certify that I am financially responsible for the above named patient and any charges that may occur.

Signature: _____ Date: _____

Dr. Raymond A. Ramos DDS
& Associates

Patient's Name: _____ Birthdate: _____

Pediatrician: _____ Why did you bring your child today? _____

General health questions:	Yes	No
Is your child in good health?		
Has there been any change in your child's general health in the past year?		
Is your child under the care of a physician now?		
Does your child see any specialists or therapists besides their pediatrician?		
Is your child taking any medications; prescription, over-the-counter, or supplements? If yes, please list with dosage: _____		

Does your child have or has your child had any of the following health issues:

	Yes	No		Yes	No
Allergies to medication:			Frequent Infections		
Allergies to food:			Genetic Disorder		
Allergies to latex, local anesthetic or metals			Heart defect, heart murmur, or any heart problem		
Allergies: Other:			Headaches		
Abnormal bleeding, blood disorders, easy bruising, hemophilia			Learning or behavioral differences		
ADD/ADHD			Hearing impaired		
Anemia			High or Low blood pressure		
Asthma/breathing or lung problems			Liver or kidney problems		
Autism/Autism Spectrum Disorder			Mental Health Concerns		
Autoimmune Disorder			Premature Birth		
Blood transfusion			Seizures or Fainting Spells		
Cancer/tumors			Sensory Issues		
Celiac Disease			Skin problems/Hives/Rash		
Cerebral Palsy			Snoring /Sleep Issues		
Congenital birth defects			Stomach Problems		
Developmental Delays			Surgeries		
Diabetes: Type I or II			Syndromes		
Endocrine system disorders			Other medical condition:		

Please explain any YES answers: _____

Does your child have or has your child had any of the following dental issues:					
	Yes	No		Yes	No
Bottle fed			Family history of missing teeth		
Breast fed			Seen an orthodontist		
Pacifier habit			Past negative dental experience		
Thumb or finger sucking habit			Dental trauma		
Tooth grinding			Speech therapy		
Tooth clenching			TMJ concerns		
Nail biting			Mouthbreathing		
Family history of dental problems, cavities,gum disease			Other dental concerns:		

How many times per day does your child brush their teeth: #_____ Do you help them?_____Yes _____No

How many times per week does your child floss their teeth: #_____ Do you help them?_____Yes _____No

Does your child use Fluoride:_____Yes _____No Circle all that apply: Toothpaste Rinse Supplements

Has your child ever been to the dentist before?_____ Yes _____ No

Name of previous dentist? _____

Did your child have dental x-rays? _____Yes _____No

What types of drinks does your child regularly drink?_____

What types of food does your child like to snack on? _____

Does your child use vitamins/supplements? _____ No _____ Liquid _____Chewable _____ Gummy

Anything else you would like us to know about your child's health or behavior?:

_____

_____

_____

_____

Parent/Guardian Name (printed): _____

Signature: _____ Date: _____

Reviewed by: _____ Date: _____

(For Office Use Only)

Dr. Raymond A. Ramos DDS
& Associates

Office Guidelines

Our goal at Raymond A. Ramos, DDS & Associates is to provide children and their parents with the tools to achieve optimal dental health. We greatly value every child entrusted to our practice as if they were our own. We embrace the opportunity to make your child's dental visit fun, exciting and educational. Our hope is that by providing you the following information we can ensure a positive, fun and long lasting relationship. Please feel free to let us know if you have any questions or concerns. Our hope is that by providing you the following information we can ensure a positive, fun and long lasting relationship. Please feel free to let us know if you have any questions or concerns.

EXPECTED PAYMENT The cost of your child's treatment will vary depending on your child's individual needs. Our team will be happy to discuss the proposed treatment plan and the fees with you. We value our relationship with you and believe communication and understanding is the key factor. It is our policy to collect payment or insurance copayments at the time of treatment. Our practice accepts payments by cash, personal checks, debit cards, all major credit cards, and Health Savings Accounts (HSA). For extensive treatment we offer outside financing through Care Credit. We can keep a credit card on file to collect any remaining copayments not paid as estimated by your dental insurance.

DENTAL INSURANCE We are happy to file your dental claims to assist you in receiving the full benefits of your child's coverage. We request you familiarize yourself with your insurance benefits, and provide us the correct information to assist you with the submittal of your child's claims. We will accept the estimated insurance payment directly from your insurance provided you authorize payment directly to our office as confirmed by your initials and if payment is received from them within 30-days. Please realize that your insurance is a contract between you, your employer, and the insurance company; therefore, we cannot guarantee coverage or eligibility and your assistance may be requested to expedite processing of delayed claims. Not all services are covered benefits in all contracts nor do plans cover 100% of all procedures; therefore, you are ultimately responsible for the total amount of your child's dental fees. Recommended treatment is indicated regardless of dental insurance benefits, deductibles, limitations, or maximums.

CANCELLATIONS/BROKEN APPOINTMENTS We consider all appointments confirmed when they are reserved yet, we are pleased to offer reminders per your preference by email or text message. If a matter arises and you need to reschedule, please provide 48 hour advance notice by calling during business hours to cancel and reschedule appointments. Doing so allows sufficient time to offer your child's appointment to another child waiting for care. A fee of $75 for cleanings, exams, x-rays and $165 for dental treatment may be charged to your account for the failure of a reserved appointment. You will need to pay this amount if you do not properly inform the office in the event of a cancellation or no show. Please understand that two consecutive missed appointments may result in the dismissal of your child as a patient.

PAST DUE BALANCES Accounts are considered past due when a balance is owed from a prior visit or an insurance payment has not been received after 30 days. Payment of any past due balance is required to be paid in full before incurring new charges. Balances over 90 days may be subject to a $25 rebilling fee and 24% monthly interest charges.

INFORMATION CHANGES To ensure your child's records remain current, please notify us of any changes related to medical history, telephone number/s, address, email, employer or insurance information as they occur, otherwise we cannot assure accuracy of billing and statement.

I understand and agree to the information above. My presented questions have been answered.

Parent/Guardian Name (printed): _____

Parent/Guardian Signature: _____ Date: _____

Patient's name printed: _____

Raymond A. Ramos, DDS and Associates
3835 Cypress Drive, Petaluma, CA 94954 T: (707) 763-1548 F: (707)763-6942

Acknowledgement of Receipt of Notice of Privacy Practices

The privacy of your protected health information is important to us. We have provided you with a copy of our Notice of Privacy Practices. It describes how your health information will be handled in various situations. We ask that you sign this form to acknowledge you received a copy of our Notice of Privacy Practices. This includes the situation where your first date of service occurred electronically.

If your first date of service with us was due to an emergency, we will try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

I have received the Privacy Notice.

_____
Print Name

_____
Signature

_____
Date

For Office Use Only:

Patient Name:_____
We attempted to obtain written acknowledgement of receipt of our office Notice of Privacy Practices, however, acknowledgement could not be obtained due to:

- ☐ Patient refused to sign
- ☐ Patient communication barrier
- ☐ Emergency Situation

Completed by:

_____
Employee Signature Title Date

Dr. Raymond A. Ramos DDS
& Associates

Authorization – Dental Care of a Minor When a Parent is not Present

Patient: _____ Birthdate: _____

Person(s) I authorize to accompany my child:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

I _____ authorize my caretaker to bring my minor child to Dr. Ray Ramos Pediatric Dentistry to provide treatment to my child that I have previously consented to. I understand this form does not permit the caretaker to consent to treatment on behalf of a legal guardian. I understand that only a legal guardian may consent to treatment for my child.

If treatment consent, that has not been previously diagnosed and accepted by a legal guardian authorized as such with this practice, is required at an appointment in which a caretaker is accompanying my minor child, the legal guardian will be contacted prior to proceeding with the treatment plan. If the legal guardian cannot be reached to provide treatment consent, the treatment will not be performed.

This authorization will remain effective unless terminated by written notice.

Phone number where parent can be contacted during treatment, if needed:

Home: _____ Work: _____ Cell: _____

Signature of parent or legal guardian: _____

Date: _____ Relationship to Patient: _____

Patient Communication Policy

It is important to note that standard email and text communication is not always secure. Email and text messages can be intercepted and for this reason, our practice does not communicate personal health information through this method. Our Practice will never ask for account information, credit card numbers, or personal information via email or text message. If you think you may have received a suspicious email or text from our practice , please contact our office immediately at:

Raymond A. Ramos, DDS and Associates
3835 Cypress Drive, Petaluma, CA 94954 T: (707) 763-1548 F: (707)763-6942

Email Appointment Confirmations

By enrolling in email appointment confirmations, you may receive non-appointment related emails throughout the course of your subscription with our office. Emails may include special offers for your specific location or alerts notifying you about important office news and events.

At this time, if you subscribe to receive email appointment confirmations, you automatically are subscribed to receive any marketing-related email. We promise that we will not spam your account with unnecessary emails, nor will we sell your information to a third party.

Text Appointment Confirmations

By enrolling in text appointment confirmations, you are authorizing our office to send text message appointment reminders to you on your provided cell phone number. You understand that you may reply with various commands to receive account information such as balances, future appointments, office location and other alerts.

You also agree that all individuals associated with your account may receive alerts referencing the account guarantor and/or dependents. Text message charges from your cell phone provider may apply.

Your enrollment indicates that your represent and warrant that you are the person legally responsible for all use of the accounts, are at least 18 years of age, and agree to all terms and conditions of use for the text messaging services.

Email To Other Doctors

Upon written request from you, we may release x-rays and treatment information to other practices and/or specialists on your behalf. Please note that all email communications from this office are sent using a secure, encrypted email program and the receiving practice will be prompted to create a username and password to securely access your records. Some offices may wish to not utilize this secure portal, in which case, a printed copy of your records can be mailed to their practice.

Patient Consent for Electronic Communication

Our office utilizes the convenience of email. By using our practice's electronic services, you agree that our office may send to you any of the following that you identify as a communication that can be sent through the internet to an email address you designate. All electronic communications from our practice to you will be sent from our secured, encrypted email server.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to or intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will verify the email address you provide.

- ☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time. My email address is: _____
- ☐ I consent only to receiving appointment reminders via email or text. I understand I can withdraw my consent at any time. My cell phone number is:_____
- ☐ I do not consent to receiving any information via email. I understand that I can change my mind and provide consent later.

_____

Printed Name (Patient/Parent) Signature (Patient/Parent) Date

Consent for Leaving Messages

I understand that my healthcare information is protected. I understand that, in order for us to leave detailed messages containing specific dental information on my voicemail or answering machine, I need to give permission for us to do so.

I give permission for messages to be left on my phone number(s) below:

☐ Cell # _____ ☐ Work # _____

☐ Home # _____ ☐ I prefer to not have voicemail messages

Regarding the following:

☐ Appointment Reminders/Changes
☐ Account Payments/Balances
☐ Cost Estimates
☐ Needed Treatment/Completed Treatment

_____

Printed Name (Patient/Parent) Signature (Patient/Parent) Date

Consent for Shared Information with Family & Friends

Under the HIPAA Privacy Law we are permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for Raymond A. Ramos and Associates and representatives at our practice to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my care or relevant for payment.

	Name	Relationship	Phone Number
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

Regarding the following:

☐ Appointment Reminders/Changes
☐ Account Payments/Balances
☐ Cost Estimates
☐ Needed Treatment/Completed Treatment

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____

Printed Name (Patient/Parent) Signature (Patient/Parent) Date

