KENNETH M. K. WOO, D.D.S. L.L.C.

WE WOULD LIKE TO GET TO KNOW YOUR CHILD BETTER!!!

PLEASE PRINT INFORMATION CLEARLY!!!

CHILD INFORMATION

Name: _____ Age:_____Sex:_____
First Middle Last

Address:_____

City: _____ State:_____ Zip Code:_____

Date of birth: _____/_____/_____ Hobbies: _____
Month Date Year

Home phone: _____ Child's School: _____

RESPONSIBLE PARTY INFORMATION

Name:_____ Relationship: _____

Address (if different from above):_____

City:_____ State:_____ Zip Code:_____

Work Phone:_____ext:_____ Cellular Phone:_____

Email Address: _____ Social Security Number (when necessary) : _____-_____-_____

Driver's License No.: _____State Issued: _____Exp. Date: ____/____/_____
Month Date Year

INSURANCE INFOMATION

Does your child have dental insurance coverage? Yes [ ] No [ ]

If yes, name of dental insurance company:_____Member ID #_____

Name of policy holder:_____ Relationship:_____

Date of birth: _____/_____/_____ SSN or ID # : _____-_____-_____
Month Date Year

Group Name/ Employer:_____

Group number for policy:_____ Does your child have secondary insurance? Yes [ ] No [ ] Name: _____

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Local Anesthetics □ Acrylic □ Metal
□ Latex □ Sulfa drugs □ NONE □ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

□ AIDS/HIV Positive	□ Cortisone Medicine	□ Hemophilia	□ Radiation Treatments
□ Alzheimer's Disease	□ Drug Addiction	□ Hepatitis A	□ Renal Dialysis
□ Anaphylaxis	□ Easily Winded	□ Hepatitis B/C	□ Rheumatic Fever
□ Anemia	□ Emphysema	□ Herpes	□ Scarlet Fever
□ Angina	□ Epilepsy/Seizures	□ High Blood Pressure	□ Shingles
□ Arthritis/Gout	□ Excessive Bleeding	□ High Cholesterol	□ Sickle Cell Disease
□ Artificial Heart Valve	□ Excessive Thirst	□ Hives/Rash	□ Sinus Trouble
□ Artificial Joint	□ Dizziness	□ Hypoglycemia	□ Spina Bifida
□ Asthma	□ Frequent Cough	□ Kidney Problems	□ Stomach Disease
□ Blood Disease	□ Frequent Diarrhea	□ Leukemia	□ Stroke
□ Blood Transfusion	□ Frequent Headaches	□ Liver Disease	□ Swelling of Limbs
□ Breathing Problem	□ Genital Herpes	□ Low Blood Pressure	□ Thyroid Disease
□ Bruise Easily	□ Glaucoma	□ Lung Disease	□ Tonsillitis
□ Cancer	□ Hay Fever	□ Mitral Valve Prolapse	□ Tuberculosis
□ Chemotherapy	□ Heart Attack	□ Osteoporosis	□ Tumors/Growths
□ Cold Sores	□ Heart Murmur	□ Pain in Jaw Joints	□ Ulcers
□ Congenital Heart Disorder	□ Heart Pacemaker	□ Parathyroid Disease	□ Venereal Disease
□ Convulsions	□ Heart Disease	□ Psychiatric Care	□ Jaundice
			□ NONE

Please explain any medical problems your child may have: _____

_____

Child's Physician:_____ Physician's office number:_____

ANNUAL MEDICAL HISTORY REVIEW AND UPDATES (For existing patients only)

DATE	NO CHANGE	CHANGE	LIST CHANGE	PATIENT SIGNATURE	DR/STAFF SIGNATURE
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____
_____	☐	☐	_____	_____	_____

CHILD'S HABITS

How often does your child brush? _____How often does your child floss? _____

Date of last Dental visit? _____Previous Dentist_____

Is your child's water fluoridated?			Yes [ ]	No [ ]	
Does Your Child take fluoride supplements?			Yes [ ]	No [ ]	
Does your child:	Yes	No		Yes	No
Suck thumb/finger	[ ]	[ ]	Chew hard objects	[ ]	[ ]
Suck/ Bite lips	[ ]	[ ]	Grind Teeth	[ ]	[ ]
Bite/ Chew nails	[ ]	[ ]	Clench Teeth	[ ]	[ ]

PAYMENT,INSURANCE, and APPOINTMENT POLICIES:

- I authorize the dentist(s) or designate staff treating my child to perform such aids deemed appropriate to make a thorough diagnosis of his/her dental needs. Upon such diagnosis, I authorize the dentist(s) to perform all recommended treatment and therapeutic procedures to include administrating medications as prescribed by the dentist(s) and mutually agreed upon me.
- **This office only perform composite/resin filling (tooth color).. Patients are fully responsible for any difference which is not paid by the insurance company.**
- I assign all dental insurance benefits to the extent permitted under my dental insurance policy to the practice. I agree and allow the provider to submit insurance forms and receive payment directly from insurance carrier with notation "Signature on File" I authorize my dentist(s) to release treatment records / x-rays or any information deemed pertinent to my insurance carrier as necessary and/or requested.
- I understand that insurance benefits are **ESTIMATES ONLY** based upon the information available to the provider by my insurance carrier at the time of service. **Eligibility IS NOT A GUARANTEE OF PAYMENT**, benefit is determined only when a claim is processed. Estimated patient portion is due at the time of the treatment. Therefore, Kenneth Woo DDS, LLC is not responsible for how my insurance company handle claims or what they pay on a claim. Once a claim is processed, any difference is due upon the receipt of a statement.
- I agree to pay for all the services rendered on my behalf or my dependents at the time of service. I agree that my unpaid claims that the carrier does not pay or any balance that extends beyond 30 days from the date of service will be assessed a service charge of 1.5% or a $20.00 late fee per month, whichever is greater. In the event that this balance should be submitted to collection, there will be a fee charge to the account of $50.00. A $20 charge will be applied to the account for each returned check and or declined credit card transaction. If these fees should be added to your account, you will be notified my mail. Fees are subject to change, in the event of a fee change the responsible party or patient will be notified prior to any dental treatment.
- **I agree that for all major treatments, a 50% deposit is required to be made prior to the date of the scheduled treatment date, unless prior arrangement is made with Carecredit, the remaining balance is due prior to final delivery or on impression date.**
- **APPOINTMENT CHANGES**
- For any necessary changes or cancellations of appointments, I_____ (Initial) will notify Dr. Woo & Associates 48 hours or the equivalent to 2 business days prior to my scheduled appointment time. If changes or cancellations are given less than 48 hours or the equivalent to 2 business days, a charge of $50 will be applied towards my account. It will need to satisfy this balance prior to scheduling future appointments. If a patient accumulates a total of (3) failed appointments without proper notice, we reserve the right to decline scheduling anymore future appointments.
- I HAVE READ THE ABOVE POLICIES,AGREE TO THEM AND HAVE HAD THE OPPORTUNITY TO HAVE ALL MY QUESTIONS ANSWERED.

X_____ X _____ _____

Parent/Guardian full name **Parent/Guardian Signature** **Today's Date**