DR. BRINDHA SUBRAMANIAN ("DR. SU")
DR. CHIAVEN PHEN ("DR. NIKKI")
991 Saratoga Avenue, Ste 220, San Jose, CA 95129 | 250 Blossom Hill Rd, Ste 100, Los Gatos, CA 95032
Ph: 408-692-KIDS (5437) | Email: info@bayareakidsdentistry.com | Web: www.bayareakidsdentistry.com

PATIENT REGISTRATION

We are excited to welcome your child to our practice!! We believe that with early intervention, individual risk assessment and close monitoring of external factors affecting growth and development, every child can grow and become their best yet. We look forward to building a great partnership with you to give your child a smile that is both healthy and beautiful for years to come. :)

Please let us know who may we thank for referring you to us: _____

Date: _____

TELL US ABOUT YOUR CHILD

First name:	Middle Name:	Last Name:	Preferred Name:
Date of birth:	Age:	Male: ☐ Female: ☐ Choose not to state: ☐	Siblings we see:
School Name:			Grade:
Home Street Address (Please no P.O. Box):			Home City, State and Zip:
Preferred Contact No.:		Preferred Email:	

PARENT(S) OR RESPONSIBLE PERSON (S) INFORMATION

PRIMARY RESPONSIBLE PERSON		
First Name:	Last Name:	
Date of Birth:	Relationship to Child:	
Employer Name:		
Home Street Address:		
City:	State:	Zip:
Cell#:	Home#:	
Email:		

SECONDARY RESPONSIBLE PERSON		
First Name:	Last Name:	
Date of Birth:	Relationship to Child:	
Employer Name:		
Home Street Address:		
City:	State:	Zip:
Cell#:	Home#:	
Email:		

Note: The parent(s) or responsible person(s) listed above are financially responsible for all services provided by Bay Area Kids Dentistry. If there is a change, please inform Bay Area Kids Dentistry prior to service(s) rendered.

APPOINTMENT REMINDERS PREFERENCES [Please choose only one option in each category]

Cell#: Primary Responsible Person Secondary Responsible Person	Email: Primary Responsible Person Secondary Responsible Person

By signing below, I _____ certify that I have read and understand the above and that the information provided by me on this form is accurate, and that it is my responsibility to inform this office of any changes in the provided information. I authorize and give full consent to Bay Area Kids Dentistry to contact either of the responsible persons listed on this form via email, text message and/or voicemail regarding my child/children's appointments and/or any payments for the service(s) rendered.

_____ _____

Responsible Person Signature Date

DR. BRINDHA SUBRAMANIAN ("DR. SU")
DR. CHIAVEN PHEN ("DR. NIKKI")
991 Saratoga Avenue, Ste 220, San Jose, CA 95129 | 250 Blossom Hill Rd, Ste 100, Los Gatos, CA 95032
Ph: 408-692-KIDS (5437) | Email: info@bayareakidsdentistry.com | Web: www.bayareakidsdentistry.com

INSURANCE DETAILS AND POLICIES

Date: _____ Child's Full Name: _____ Birth Date: _____

PRIMARY DENTAL INSURANCE			SECONDARY DENTAL INSURANCE Not applicable ☐	
First Name:	Last Name:		First Name:	Last Name:
Date of Birth:	Relationship to Child:		Date of Birth:	Relationship to Child:
Employer Name:			Employer Name:	
Insurance name:			Insurance name:	
Member ID or Subscriber ID# (Please no policy #.):			Member ID or Subscriber ID# (Please no policy #.):	
SSN# (If Member ID or Subscriber ID# unavailable):			SSN# (If Member ID or Subscriber ID# unavailable):	
Insurance card available: Yes ☐ No ☐ (If yes, please email us a copy.)			Insurance card available: Yes ☐ No ☐ (If yes, please email us a copy.)	

INSURANCE POLICIES **INITIALS**

Courtesy notification: If you have eligible insurance to help pay for your child's visit, we are happy to bill your insurance as a courtesy. Most of our claims are filed electronically to keep the process efficient and timely.	
Eligibility check: Prior to your visit, we make every effort to verify your dental insurance coverage and gather the relevant information, based on details provided to us at the time your child's appointment was scheduled. Until we have verified your coverage, you may be responsible for paying for your child/children's care at each visit including the first visit. After we verify your coverage and the dental insurance pays for the services rendered, we will credit the amount to your child/children's account. Kindly note that eligibility is not a guarantee of payment. When the services are complete and a claim is received for payment, your dental insurance will calculate its payment based on your current eligibility, amount remaining in your annual maximum and any deductible requirements.	
Insurance network status: In order to be able to practice dentistry that aligns with our practice philosophy, we may choose to either contract or not contract with dental insurances. For patients who see us as an out-of-network dentist, we offer reduced prices similar to an in-network dentist to lessen the financial burden on the families and as an appreciation for choosing us. Our goal is to remove finances as a decision point while making health related choices for your child/children.	
Payment commitment: Based on your dental insurance benefit plan terms, the dental insurance may cover all or only part of your child's dental treatment. We will do our best to provide you with an estimate. All estimated copayment or coinsurance amounts are due at the time of services rendered. If after billing your insurance a balance is still owed you will be billed or informed during your child/children's future visit. Any balance billed not paid within 30 days of informing you will incur a fee of 1.5% each month on the unpaid balance. Please understand that the contract for dental insurance is between you and your insurance company. Any disputes of insurance coverage need to be addressed with your insurance company directly by you.	
Assignment of benefit: You agree to have your insurance company pay us directly. Instead of paying us if the insurance pays you for any services rendered, we expect you to pay us within 15 days of receipt of that payment.	

By signing below, I _____ certify that I have read and understand the above terms and that the information provided by me on this form is accurate, and that it is my responsibility to inform this office of any changes in the provided information and accept full responsibility for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____ _____
Responsible Person Signature Date

DR. BRINDHA SUBRAMANIAN ("DR. SU")
DR. CHIAVEN PHEN ("DR. NIKKI")
991 Saratoga Avenue, Ste 220, San Jose, CA 95129 | 250 Blossom Hill Rd, Ste 100, Los Gatos, CA 95032
Ph: 408-692-KIDS (5437) | Email: info@bayareakidsdentistry.com | Web: www.bayareakidsdentistry.com

PATIENT DENTAL AND MEDICAL HISTORY

Date: _____ Child's Name: _____ Birth Date: _____ Child's Age:_____

Person completing this form: _____ Relationship to Child: _____

DENTAL HISTORY

Is this your Child's first visit to the Dentist? Yes ☐ No ☐	If not, tentatively how long ago was the last visit?	Previous Dentist's Name:	Reason for changing Dentists:
Is your Child currently in pain? Yes ☐ No ☐	What is the primary reason for today's visit?		
Has your Child experienced problems with previous dental work? Yes ☐ No ☐ If yes, please explain:		Does your Child have any dental x-rays taken within the last six months? Yes ☐ No ☐ If yes, please share with us.	
Does your Child brush his/her own teeth? Yes ☐ No ☐ How often per day? 1x ☐ 2x ☐ If 1x, Morning ☐ Night ☐		If not, do you brush your Child's teeth? Yes ☐ No ☐ How often per day? 1x ☐ 2x ☐ If 1x, Morning ☐ Night ☐	
Does your Child floss his/her own teeth? Yes ☐ No ☐ How often per day? 1x ☐ 2x ☐ If 1x, Morning ☐ Night ☐		If not, do you floss your Child's teeth? Yes ☐ No ☐ How often per day? 1x ☐ 2x ☐ If 1x, Morning ☐ Night ☐	
Is your Child taking fluoride? Yes ☐ No ☐		Is your water fluoridated? Yes ☐ No ☐	
Does your child have any special fears or concerns (i.e. afraid of doctors, bugs, etc.)?			
Does/Did your child have or do any of the following?			
Nail Biting	Chewing on Objects	Pacifier Usage	Breast Fed
Lip Sucking / Biting	Nursing Bottle Habits	Tongue Thrust	Speech Problems
Clenching / Grinding Teeth	Thumb / Finger Sucking	Tongue /Cheek Biting	Sippy Cup Usage
Snoring	Tonsilectomy/Adenoidectomy	Surgery	Sports

MEDICAL HISTORY

Child's Physician's Name?	Phone #:	Street Address:	City, State, Zip:	Date of Last Visit:
Is your Child currently under the care of Physician? Yes ☐ No ☐ Please explain:				
Please describe the Child's current physical health: Good ☐ Fair ☐ Poor ☐			Are immunizations current? Yes ☐ No ☐	
Please list all drugs the Child is currently taking:				
Please list all drugs/over the counter products and/or things that cause the child allergic reaction:				

Does/Did your child have or do any of the following?

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding			Blood Disorders			Kidney disease		
Excessive Bleeding after dental work			Anemia			Hearing loss		
Allergies			Sickle cell anemia			Cerebral Palsy		
Asthma			Hemophilia			Chicken Pox		
Autism/Behavior Disorder			Heart Disease			High Blood Pressure		
Diabetes			Heart murmur			Low Blood Pressure		
Epilepsy or seizures			Heart congenital defect			Cancer		
Hepatitis or liver disease			History of rheumatic fever			Skin Rash		
AIDS/HIV+			Recurrent Tonsillitis			Tuberculosis (TB)		
Other:								

I certify that I have read and understand the above and that the information given on this form is accurate, and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize and give full consent to perform dental services agreed upon between doctor and patient representative to be necessary or advisable for my child/children including examination, radiographs, prophylaxis (cleaning of teeth) and application of fluoride. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. By signing this I indicate that I have legal authorization to consent to care and treatment for my child/children by Bay Area Kids Dentistry.

_____ Signature of Legal Responsible Person

_____ Print Name of Legal Responsible Person

_____ Date

DR. BRINDHA SUBRAMANIAN ("DR. SU")
DR. CHIAVEN PHEN ("DR. NIKKI")
991 Saratoga Avenue, Ste 220, San Jose, CA 95129 | 250 Blossom Hill Rd, Ste 100, Los Gatos, CA 95032
Ph: 408-692-KIDS (5437) | Email: info@bayareakidsdentistry.com | Web: www.bayareakidsdentistry.com

OFFICE POLICIES AND ADDITIONAL INFORMATION

We acknowledge that at first glance the information below might seem overwhelming. Our goal is to not get you lost in large amounts of information. Our goal is TRANSPARENCY. We want to lay out all the details for you to read to lower the chances of surprises for both of us. We appreciate you taking time to read and understand the details below. Please feel free to reach out to us with any questions you might have. :)

Dental appointments:

1. We attempt to schedule appointments at your convenience and when time is available. We suggest preschool children be seen in the morning because they respond better, and we can work more slowly with them for their comfort. This applies to school children with a lot of dental work to be done as well.
2. We use a practice management software to send you appointment reminders. This includes email, voicemail or text. Response to the reminder is mandatory. Failure to respond to an appointment reminder will be considered as a default request for reschedule and the appointment slot will be opened for another child in need.
3. If you need to cancel your child/children's appointment, we request two business days' notice. Another patient, who needs our care, could be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your assistance in this regard. However, if you do miss an appointment without notifying us two business days in advance, a cancellation fee of $75 may be applied to your child/children's account.

Insurance and Payment Commitments:

1. Please understand that we submit dental insurance as a courtesy to our patients. However, you are responsible for knowing your benefits and understanding the contract upon which you have chosen for coverage. Based on your dental insurance benefit plan terms, the dental insurance may cover all or only part of your child's dental treatment. All estimated copayment or coinsurance amounts are due at the time of services rendered.
2. If after billing your insurance a balance is still owed you will be billed or informed during your child/children's future visit. Any balance billed not paid within 30 days of being informed either by insurance or our office will incur a fee of 1.5% each month on the unpaid balance.
3. The contract for dental insurance is between you and your insurance company. Any disputes of insurance coverage need to be addressed with your insurance company directly by you. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We at no time guarantee what your insurance will or will not do with each claim. We also cannot be responsible for any errors in filing your insurance if the correct information is not provided.
4. In order to be able to practice dentistry that aligns with our practice philosophy, we may choose to either contract or not contract with dental insurances. For patients who see us as an out-of-network dentist, we offer reduced prices similar to an in-network dentist to lessen the financial burden on the families and as an appreciation for choosing us. Our goal is to remove finances as a decision point while making health related choices for your child/children.
5. You agree to have your insurance company pay us directly. Instead of paying us if the insurance pays you for any services rendered, we expect you to pay us within 15 days of receipt of that payment.
6. In the instance your child/children do not have insurance, full treatment payment is due at the time of services rendered.

Treatments:

1. We rely on the American Dental Association (ADA), Academy of Pediatric Dentistry (AAPD) and the American Academy of Pediatrics (AAP) guidelines and the individual risk assessment of each child to recommend the dental treatment plan.
2. Based on the terms of your insurance coverage, certain recommended services such as fluoride, laughing gas etc. may not be covered service at each visit. Once the service is rendered you will be responsible for the full payment. If you choose not to have the recommended service for your child/children, please let us know before the service is rendered. Please understand that based on the child's need the Doctor will discuss with you the impact of refusing a service.

Infection Control and Sterilization:

1. We follow the Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA) guidelines on infection control. Per the CDC recommendation for dental offices, we sterilize dental handpieces according to manufacturers' instructions.

DR. BRINDHA SUBRAMANIAN ("DR. SU")
DR. CHIAVEN PHEN ("DR. NIKKI")
991 Saratoga Avenue, Ste 220, San Jose, CA 95129 | 250 Blossom Hill Rd, Ste 100, Los Gatos, CA 95032
Ph: 408-692-KIDS (5437) | Email: info@bayareakidsdentistry.com | Web: www.bayareakidsdentistry.com

OFFICE POLICIES AND ADDITIONAL INFORMATION CONTD.

2. All digital radiography sensors are protected with an FDA cleared barrier to reduce contamination during use followed by high level disinfection between patients.
3. Automated cleaning equipment (ultrasonic cleaner) is used to remove debris to improve cleaning effectiveness. After which the instruments are packed in single use pack for heat sterilization with an autoclave. Spore tests are performed weekly to test efficiency of the sterilization process.
4. Dental unit water quality is checked quarterly and water is constantly treated with a low-level antimicrobial.

Administrative requests

1. You may request copies of your Child/Children's health information, with limited exceptions by using the contact information listed at the top of this page. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, we may provide you an electronic copy. We will use the form and format you request if readily producible.
2. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you.
3. For school related oral health assessment forms, please complete the child portion of the form prior to sending it to us. You may mail or email it to us at the contact information listed at the top of this page, based on your child/children's school requirements.
4. If you need supporting documentation for tax purposes, please send us an email at the contact information listed at the top of this page.
5. For all administrative requests, we may require 3 to 7 business days. Please plan your request accordingly. Specifically, for supporting documentation for tax purposes we may require more than 7 business days as we rely on information from your insurance in certain instances.

Acknowledgement of Receipt of the Notice of Privacy Practices:

Under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding your, your Child/Children's protected health information (PHI). By signing this form, you acknowledge access or receipt and understand Bay Area Kids Dentistry's Notice of Privacy Practices containing the complete description of the uses and disclosures of your, your Child/Children's PHI. You understand that Bay Area Kids Dentistry has the right to change its Notice of Privacy Practices from time to time and that you may contact Bay Area Kids Dentistry at any time to obtain a current copy of their Notice of Privacy Practices.

Dental Materials Fact Sheet:

This is information provided by the dental board of California to advise patients of the types of materials used in the dental office. You can access the Dental Materials Fact Sheet by clicking on the link below. By signing this form, you acknowledge receipt of the fact sheet.
https://www.dbc.ca.gov/formspubs/pub_dmfs_english_webview.pdf

By signing below, I _____certify that I have read and fully understand the above terms. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. By signing this I indicate that I have legal authorization to consent to care and treatment for my child/children by Bay Area Kids Dentistry.

_____ _____

Responsible Person Signature Date