Brian C. Quo, DDS, MS
882-A Emerson St.
Palo Alto, CA 94301
(650) 853-8883

Peninsula Pediatric Dentistry
Caring For Children & Young Adults

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 any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

Date: __________________

Name of Minor/Child: ____
First Name Middle Initial Last Name

Nickname: ______________________ Birthdate: __________________ Sex: M F Age: ______________

Home Address: ____
Street City State Zip

Mailing Address: ____
Street City State Zip

Person Financially Responsible (Name of Insured): ______________________________________

Home Number: (______) ______________________ Work/Cell Number: (______) ______________________

Whom may we thank for referring you? ______________________________________

Fathers/Guardian's Name: ______________________________

Address (if different from patient's) ______________________________

____

Home Phone: (_____) ______________________
(if different from above)
E-Mail: ______________________________

Soc. Sec. #: ______________ D.O.B.: ____________

Employer: ______________________________

Do you have dental insurance coverage for minor/child? Yes No

Plan Name: ____________ Phone: (____) ______________

Address: ______________________________

ID #: ________________ Group #: ______________

Mother's/Guardian's Name: ______________________________

Address (if different from patient's) ______________________________

____

Home Phone: (_____) ______________________
(if different from above)
E-Mail: ______________________________

Soc. Sec. #: ______________ D.O.B.: ____________

Employer: ______________________________

Do you have dental insurance coverage for minor/child? Yes No

Plan Name: ____________ Phone: (____) ______________

Address: ______________________________

ID #: ________________ Group #: ______________

Date of last visit to a dentist: ____________ For what service? ______________________________

	YES	NO
Has child complained about dental problems? ……………………		
Does child brush teeth daily? ………………………………………		
Does child floss every day? ………………………………………..		
Is fluoride taken in any form? …………………..		
Any injuries to mouth, teeth, head? ……............		
Any unhappy dental experiences ………………..		
Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? ……………………………………..		

Please Complete Both Sides

Minor/Child's Physician: ___________________________________ City/State: ______________________ Phone: (____) _______________________

Date of last physical examination: ___________________ Results: ____

Allergy to any medications or Latex? (If so, list them): ____

	YES	NO	
Is Minor/Child under care of physician right now? ……………..			Medications: ____
Receiving any medications 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? Please check yes or no:

Yes/No

A.I.D.S./H.I.V.	Cancer	Diabetes	Kidney Disease	Rheumatic Fever
Anemia	Cerebral Palsy	Epilepsy/Seizures	Liver Disease	Sinus Problems
Asthma	Chicken Pox	Hearing Problems	Measles	Thyroid Disease
Autism	Convulsions	Heart Problems	Mononucleosis	Tuberculosis
Bladder Problems	Developmental Delay	Hepatitis	Mumps	Other

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

Name: ____ Relationship: _________________________ Phone: (_____) __________________________

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

Minor/Child Consent

I am the parent, guardian, or personal representative of ____ 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 treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with ____ and assign directly to
Name of Insurance Company(ies)
Dr. Brian C. Quo, DDS, MS 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.

Dr. Brian C. Quo, DDS, MS may use my minor's/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 of the benefits payable for related services.

____ ___________________________
Signature of Parent, Guardian, or Personal Representative — Date

____ ___________________________
Please print name of Parent, Guardian, or Personal Representative — Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____ have received a copy of this office's Notice of Privacy Practices.
Parent/ Guardian Name Printed

FOR OFFICE USE ONLY

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

Individual refused to sign
Other (Please specify)

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OUR FINANCIAL POLICY

Thank you for choosing us as your child's health care provider. We are committed to your child's treatment being successful. The following is a statement of our FINANCIAL POLICY which we require you to read and sign prior to any treatment.

- **All patients must complete our Information and Insurance form before seeing the doctor.**
- **Full payment is due at the time of service.**
- **We accept Cash, Check, and VISA/MC.**

REGARDING INSURANCE

We are contracted with Delta Dental Insurance and we will collect the estimated co-pay at the time of service. For all other insurances, payment is required in full at the time of service and as a courtesy we will process all of the insurance claim forms so you can receive your maximum benefit.

Since many plans do not cover all of the procedures required for your treatment plan, you may have a portion that will be your responsibility. This could include: deductibles, co-pays, and any other self-pay portions.

We cannot bill your insurance unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all of the services provided may not be covered and not considered reasonable by your insurance.

USUAL AND CUSTOMARY RATES

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.

MINOR PATIENTS

The adult accompanying a minor is responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to and payment has been arranged. (See above for payment methods.)

MISSED APPOINTMENTS

Unless canceled at least 24 hours in advance, our policy is to charge $75.00 for missed appointments. Please help us serve you better by keeping scheduled appointments and showing up at the time of your scheduled appointment.

Thank you for understanding our FINANCIAL POLICY. Please let us know if you have questions or concerns.

I have read and understood the Financial Policy.

____________________________________ ________________

Parent/Guardian Signature Today's Date

____

Parent/Guardian Name Printed

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INFORMED CONSENT

Our dental office philosophy is based on our preventative dentistry and to creating a supportive and nurturing environment for the children and young adults under our dental care. In particular, we are dedicated to providing safe, comfortable and quality dental treatment for all our patients.

California State Law requires us to obtain your informed consent before we can provide any dental services for your child. Our most important general office policy is to "inform before we perform". Specifically, we are requesting your permission for the following diagnostic and preventive dental procedures: comprehensive clinical examination, selected diagnostic x-rays, thorough professional cleaning and decay-fighting fluoride treatment.

If dental treatment is necessary, we require your consent for a number of additional procedures which include, but are not limited to, the following: local anesthesia ("lidocaine"), low-level nitrous oxide –oxygen "laughing gas", comfortable mouth prop ("tooth pillow") and extensive use of classic "tell-show-do" method of introducing new methods and materials to your child.

You will be verbally informed before dental treatment is performed on your child. Please feel free to ask us any questions you may have regarding the preceding information or concerning any other aspect of our dental practice. Additionally, you may wish to discuss our policies with other individuals who are involved in caring for your child.

Thank you for taking the time to read and sign this important document.

Therefore, I hereby give my consent to Brian C. Quo, DDS, MS, to provide mutually agreed upon dental services for my child. I further agree that that this consent shall remain in force unless withdrawn in writing by the person who has assigned below of the minor patient or themselves.

______________________________	______________________________
PRINT PATIENT'S NAME(S)	PATIENT'S AGE(S)
______________________________	______________________________
PARENT/GUARDIAN'S SIGNATURE	PARENT/GUARDIAN'S NAME PRINTED
______________________________	______________________________
RELATIONSHIP TO PATIENT(S)	TODAY'S DATE
______________________________	______________________________
OFFICE PERSONNEL WITNESS SIGNATURE	OFFICE PERSONNEL WITNESS NAME PRINTED