490 S. Farrell Dr. Ste. C-101
Palm Springs, CA. 92262

Lauren L Gutenberg, DDS, MSD
Steven J Niethamer, DMD

7144 Airway Avenue
Yucca Valley, CA. 92284

PEDIATRIC DENTISTRY HEALTH HISTORY AND PATIENT INFORMATION

This confidential information is of great value in aiding us to better understand and treat your child.

REASON FOR VIST_____ **Date**_____

Child's Name_____ Pref.Name_____ SEX M F

Age_____ Date of Birth_____ School _____ Grade _____

Name & Age of Brothers & Sisters _____

Kind & Name of any pet(s) _____

What is your child most interested in? _____

Child's Physician_____ Phone Number _____

City_____ Date last seen _____

Family Dentist_____ City _____

	HISTORY	**CIRCLE**	
1.	Is your child being treated by a physician at this time?	YES	NO
	If yes, Why? _____		
2.	Has your child ever been hospitalized or had surgery? ……..	YES	NO
	If yes, Why? _____		
3.	Has your child ever received general anesthesia or sedation? ……	YES	NO
	If yes, why, and when? _____		
4.	Is your child allergic to anything? (Medicine / Food /Latex) ……...	YES	NO
	If yes, what? _____		
5.	Is your child taking any medications at this time? ……...	YES	NO
	If yes, medicine and dosage _____		
6.	Has your child ever had a blood transfusion? ……..	YES	NO
7.	Does your child have any blood disorders (anemia, etc.)? ……	YES	NO
8.	Is your child subject to any nervous disorders, fainting or dizziness? ……	YES	NO
9.	Does your child bruise easily? ……	YES	NO
10.	Has your child a history of heart trouble, murmurs or rheumatic fever? ……..	YES	NO
11.	Has your child a history of asthma? ……..	YES	NO
12.	Has your child a history of diabetes? ……	YES	NO
13.	Does your child have a handicapped problem or learning disabilities? ……...	YES	NO
14.	Is this your child's first dental visit? ……	YES	NO
	Previous dentist _____ City _____ Last seen _____		
15.	Has your child had an unfavorable experience in a previous dental / medical office? ……...	YES	NO
	How do you think he/she will act toward the dentist? _____		
16.	At what age did your child stop bottle/breast feeding? _____		
17.	Have there been any injuries to your child's teeth or jaws? (falls, blows, chips, etc.) ……	YES	NO
18.	Is your child taking a fluoride supplement or drinking fluoridated water? ……	YES	NO
19.	Does you child suck his/her thumb or fingers? ……...	YES	NO
20.	How often does your child brush his/her teeth? _____		
21.	What type of toothpaste does your child use? _____		
22.	Is dental floss used? ……	YES	NO
23.	Does your child have a problem with his/her bite or position of any teeth? ……	YES	NO
24.	Is there any history of missing or extra teeth in the family? ……...	YES	NO
25.	Has your child been seen by an orthodontist? ……	YES	NO
26.	Has your child had any sores or swellings of his/her mouth or jaws? ……..	YES	NO
27.	Has your child had frequent sores in his/her mouth? ……	YES	NO
28.	Has your child ever had dental radiographs (X-rays) made? ……	YES	NO
	If yes, when? _____		
29.	Have you been satisfied with your child's previous dental care? ……..	YES	NO
	If no, why? _____		
30.	Is your child adopted? ……..	YES	NO
	Does your child know? ……	YES	NO
31.	Who referred you to our office? _____		
32.	Is there anything else we should know about your child? _____		
	_____		

>>>>>>>>>>PLEASE COMPLETE REVERSE SIDE ALSO<<<<<<<<<<

ORGANS AND SYSTEMS

Has this child had any treatment for any of the following? Please circle all that apply:

Blood – Circulatory	Eye	Liver	Respiratory – Lungs
Bones	Gastrointestinal – Stomach	Muscles	Skin
Endocrine Glands	Kidney – Bladder	Nervous System	Tonsils / Adenoids
Ears	Heart	Nose / Throat	

ILLNESS

Has the child ever been diagnosed as having any of the following conditions? Please circle all that apply:

Anemia	Diphtheria	Measles	Sickle Cell Anemia
Allergy	Drug or Alcohol Abuse	Mental Retardation	Sinus Problems
Arthritis	Emphysema	Mumps	Skin Rash / Hives
Asthma / Hay fever	Epilepsy	Mouth Breathing	Snoring At Night
Autism	Eye Problems	Nutritional Deficiency	Spina Bifida
Brain Injury	Excessive Bleeding Problem	Orthopedic Problems	Syndrome _____
Bronchitis	Fainting	Pregnancy / Pregnant	Tetanus
Cancer	Hearing loss	Pneumonia	Thyroid Disease
Cerebral Palsy	Heart Disease	Polio	Tuberculosis
Chicken Pox	Hemophilia	Premature Birth	Venereal Disease
Cleft Lip / Palate	Hepatitis – Type_____	Psychiatric Disorder	Whooping Cough
Convulsions / Seizures	AIDS	Rheumatic Fever	Other _____
Developmental Disabilities	Jaundice	Scarlet Fever	_____
Diabetes	Leukemia	Scoliosis	_____

FAMILY INFORMATION

Residential Address of Patient_____ City_____ Zip_____

Parent 1 _____ Phone _____ Birthdate _____
Residential Address _____ City_____ Zip _____
Employer _____ Occupation _____ Phone _____
Business Address _____ City _____ Zip _____

Parent 2 _____ Phone _____ Birthdate _____
Residential Address _____ City_____ Zip _____
Employer _____ Occupation _____ Phone _____
Business Address _____ City _____ Zip _____

FINANCIAL RESPONSIBILITY

Person responsible for child's financial support_____ Phone _____ Birthdate _____
Residential Address _____ City_____ Zip _____
Social Security No. _____ Drivers License No. _____
Employer _____ Occupation _____ Phone _____
Business Address _____ City _____ Zip _____

INSURANCE INFORMATION

Is your child covered by a dental insurance plan? …… YES NO

Name of Insurance Company _____ Group / Policy No. _____
Name of the Insured Parent _____ Social Security No. _____

If in Military please give: Parents Pay Grade_____ **Commanding Officer:** _____

AUTHORIZATION

I here by authorize Dr. Lauren L. Gutenberg and/ or her associates to perform any and all treatment for my above named child, and consent to such methods, drugs, and agents as may be indicated in connection with his / her dental care. This consent shall remain in effect until cancelled.

Signature _____ **Date** _____
Relationship to child _____

PLEASE NOTE: **Payment is expected for services rendered at the time of the first visit**. Financial arrangements for subsequent treatment may be made following the diagnosis. THANK YOU

Lauren L Gutenberg, DDS, MSD
Steven J Niethamer, DMD

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Diplomates,
American Board of
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F: (760)365-4449

COMMUNICATION OF INFORMATION

From time to time, our office will have reason to contact you regarding information pertaining to your appointment, prescription, surgery, visits, etc. Please check the following means of communication which are acceptable to you.

( ) Text
( ) Call & speak only with you
( ) Call & leave message with anyone who answers the phone or answering machine
( ) E-mail

Please give us the telephone number(s) with an area code you would like us to contact you at:

Home _____

Parent 1 name/cell _____

Parent 2 name/cell _____

Work _____

E-mail _____

_____ _____

(Signature of Parent/Guardian) (Date)

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Notice of Privacy Practices

This notice describes how health information about you/or your child(children) may be used and disclosed and how you can access to this information. Please review carefully. The privacy of your health information is important to us.

Our Legal Duty

We are required by law to maintain the privacy of your health. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy the privacy practices that are described in this Notice while it is in effect. This notice takes effect on 7/14/2016 and will remain in effect until we replace it.

We reserve the right to make changes to our privacy practices, provided such changes are permitted by applicable law. Following any changes, we will we will make the new notice available upon your request. You may request a copy of this notice at any time. We will post our notice in our office and on our website: www.steveniethamer.com .

Uses & Disclosures of Health Information

We may use and disclose health information about you or your child/children for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose you or your child's health information to another dentist, or healthcare provider providing treatment to you, or if we refer you to another healthcare provider.

Payment: We may use and disclose you or your child's health information to obtain payment for services we provide to you. We may share part of it with your insurance company, collection agencies or attorney assisting with collections, and others who are responsible for your bills, such as spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that was done to your dental insurance company so it will pay us or reimburse you for the dental procedure.

Health Care Operations: We may use and disclose you or your child's health information in connection with our health care operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing or credentialing activities.

Your Authorization: In addition to our use of you or your child's health information for treatment, payment, or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it, in writing, at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family, Friends, & Persons Involved in Care: We must disclose you or your child's health information to you, as described in the Patient Rights section of this notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree may we do so, or based on our professional judgement, we determine that you would not object to the disclosure. We will also use our professional judgement and our experience in allowing a person to pick up supplies, x-rays, or other similar forms of health information on your behalf.

Marketing Health-Related Services: We will not use you or your child's health information for marketing communications without your written consent/authorization.

Please See Reverse Side

Contacting You: We may use and disclose you or your child's health information to contact you about appointments and other matters. We may contact you by telephone call, text messaging, email, or by mail. We may leave you messages at the telephone numbers you provide us with.

Patient Rights

Access: You have the right to look at or get copies of you and your child's health information, with limited exceptions. You written request is necessary. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. We may charge a fee for producing dental records and x-rays as allowed by law.

Disclosure Accounting: You have the right to receive a list of instances in which we/our business associates disclosed you or your child's health information for purposes other than treatment, payment, and healthcare operations, and certain other activities for the last six years, but not before 2003.

Restrictions: You have the right to request that we place additional restrictions, but if we do, we will abide by our agreement (except in emergency). When you pay in full outside of your insurance plan for services, you may request that we restrict this information and not disclose it to your healthcare plan or insurer.

Alternative Communications: You have the right to request that we communicate with you about you or your child's healthcare information by alternative means or to alternative locations. This request must be in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation or how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend you and your child's health information. This request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you received this notice on our website or by email, you are also entitled to receive this notice in written form.

Questions & Concerns

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of you and your child's health information. We will not retaliate in any way if you choose to file a complaint with us or the U.S. Department of Health and Human Services.

Lauren L Gutenberg DDS, MSD & Associates
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F: (760)320-3144

OFFICE COPY

If you would like a printed copy for your records, please ask the front desk/reception.

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Lauren L Gutenberg, DDS, MSD

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Acknowledgement of Receipt of Notice of Privacy Acts

Purpose: This form is used to obtain acknowledgment of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain acknowledgement.

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, the parent/legal guardian of, _____
(child/children's name)
have received a copy, or have had access to a copy of this office's Notice of Privacy Practices.

Parent/Guardian's Name: _____ Date: _____

Parent/Guardian's Signature: _____

Authorization to Release Information to People other than Yourself

Purpose: This form is used to obtain authorization to release information regarding you and/or your child/children covered under the Privacy Act to people other than yourself. I, parent/legal guardian of the above named children, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself and/or child/children. (i.e. step-parent, nanny, grandparent etc.)

Parent/Guardian's Signature: _____

_____
Print Name & Relationship to Patient

_____
Print Name & Relationship to Patient

_____
Print Name & Relationship to Patient

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California Authorization for the Release of Dental Records

I hereby authorize _____, DDS to release the information in the dental record of
(Dentist's Name)

_____
(Patient's Name)

to_____
(Name of Dentist, Physician, Clinic,
or Patient's Representative)

(Address and Email)

[I understand and agree to pay a reasonable charge to cover the cost of transfer, as allowed in the Health and Safety Code §§123100 *et seq* and Evidence Code §1158]

This authorization is effective now and will remain in effect until **indefinitely**/_____.
(date)
I understand that I may receive a copy of this authorization.

Signed: _____ Date:_____

If not signed by the patient, please indicate relationship:
[ ] Parent or Guardian of minor patient
[ ] Guardian or Conservator of an incompetent patient
[ ] Beneficiary or Personal Representative of deceased patient

COPY TO BE PLACED IN PATIENT'S CHART

drstevenniethamer@verizon.net

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Payment Method/Dental Insurance Policy & Info.

[ ] I will be paying out-of-pocket and agree to make all payments (unless prior arrangements have been made) at the time services are rendered per office policy.

[ ] My child(ren) are covered under a dental insurance policy and I agree to give your office any necessary information needed for billing purposes.

We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage. The insurance relationship constitutes an agreement between the **carrier** and the **patient**. As such, we can make no guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your current policy.

Subscriber Name: _____

Date of Birth: _____ Subscriber ID/SSN: _____

Group/Employer Name: _____ Group #: _____

Insurance Name: _____

Insurance Telephone #: _____

Military Parents:
Paygrade: _____ **Commanding Officer**: _____

Please **initial** your acknowledgement of the following:

_____ I authorize release of any information concerning my child/children's healthcare recommendations & treatment for the purpose of evaluation & administering claims for insurance benefits.

_____ I authorize payment of insurance benefits directly to Lauren L. Gutenberg, DDS, MSD. &/or Steven J. Niethamer, DMD.

_____ I understand that my dental insurance benefits may be less than the fees for dental services & may not pay the fee charged in full.

_____ I understand that because you **cannot guarantee my EXACT insurance coverage, there may be a balance remaining after insurance payment is received**.

_____ I understand that I am responsible for & agree to pay all fees for my child/children's dental treatment.

_____ I agree to pay any applicable deductibles & estimated copayments on the date dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan & I agree to pay for any non-covered services on the date the dental services are rendered.

_____ I agree to pay the total cost of dental services rendered on the date of service if my child/children do not have dental insurance benefits.

Parent/Guardian Signature: _____ Date: _____