Patient Registration Form

Personal Information

Patient's Name:_____
First Last
Gender: Male or Female (circle one) Preferred name:_____

Date of Birth:_____/_____/_____

Social Security #: _____-_____-_____

Referral Source:_____
(dentist, friend, physician, phonebook, internet)

Address/Contact Information

Address:_____

City:_____ Zip:_____

Home Phone: (_____)_____-_____

Other Phone: (_____)_____-_____

Other family members seen here:_____

Parents (or guardian): Single_____ Married_____ Divorced_____ Widowed_____

Mother's Name (or Legal Guardian):_____ DOB:____/____/____ SS#:_____/_____/_____
First Last
Phone:_____ Employer:_____

Father's Name (or Legal Guardian):_____ DOB:____/____/____ SS#:_____/_____/_____
First Last
Phone:_____ Employer:_____

Person Responsible for Account, if different from above

Guarantor's name:_____ SS#:_____-_____-_____

Address:_____
Number Street City State Zip

Phone #: (_____) _____-_____ Alternate Phone #: (_____) _____-_____

Relationship to Patient:_____

Insurance Information

Primary Insurance Name:_____ Secondary Insurance Name:_____

Group #:_____I.D.#_____ Group #:_____I.D.#_____

I authorize and request treatment from Children's Dentistry of the Rockies. I authorize the use of diagnostic aids, medications, patient photos, and procedures that are necessary in the professional judgment of the treating dentist. I authorize the release of information relating to my child's dental care for insurance purposes and authorize payment of the insurance benefits directly to Children's Dentistry of the Rockies for treatment performed on my child. I understand that as a courtesy, this office will bill my insurance carrier according to the information I have provided above. I further understand that my dental insurance is a contract between me and the insurance carrier, and that I am still fully responsible for the entire dental fee. I agree that I am financially responsible for the cost of treatment as well as any collection costs, court costs, attorney fees and any delinquent account fees. I understand that should my account become delinquent it could be subject to an 18% annual interest rate.

Parent/Legal Guardian:_____ Date:_____

Email(to be used for appointment reminders):_____

Medical & Dental History Form

Name:_____ _____ Date:_____
FIRST LAST AGE

Physician Name:_____ Previous Dentist Name:_____

Date of Last Visit:_____ Date of last dental visit:_____

Medical History

Please check the appropriate answers	**YES**	**NO**
Child's Doctor/Address_____		
Is your child taking medication now?	☐	☐
If so, for what condition(s)?_____		
Please list medication(s):_____		
_____		
Has your child ever been hospitalized?	☐	☐
Has your child ever had a serious illness or operation?	☐	☐
If so, please explain:_____		
Are your child's immunizations up to date?	☐	☐
Does your child have a history of any of the following?		
1. Asthma	☐	☐
2. Diabetes	☐	☐
3. Heart trouble	☐	☐
4. Rheumatic fever	☐	☐
5. Bleeding disorder	☐	☐
6. Respiratory problems	☐	☐
7. Cerebral palsy	☐	☐
8. Brain injury	☐	☐
9. Epilepsy	☐	☐
10. Liver disorder	☐	☐
11. Kidney trouble	☐	☐
12. Emotional/Nervous disorder	☐	☐
13. Mental handicap	☐	☐
14. Physical handicap	☐	☐
15. Speech disorder	☐	☐
16. Hearing disorder	☐	☐
17. HIV/AIDS	☐	☐
18. Hepatitis	☐	☐
19. Tuberculosis	☐	☐
20. Autism/Asperger's	☐	☐

Other:_____

Allergies(list)_____

_____

Dental History

Please check the appropriate answers	**YES**	**NO**
Has he/she had any serious problems associated with any previous dental treatment?	☐	☐
If so please describe:_____		
_____		
Date of last dental xrays:_____		
Has he/she ever had orthodontic treatment?	☐	☐
Do his/her gums bleed when brushing teeth?	☐	☐
Has he/she often had toothaches?	☐	☐
Has he/she had frequent sores in his/her mouth?	☐	☐
Has he/she had any injuries to his/her mouth or jaws?	☐	☐
Has your child had a past negative dental experience?	☐	☐
Does your child have a history of thumbsucking?	☐	☐
Does your child have a disability that prevents treatment in an outpatient dental office?	☐	☐

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/her medication, I will inform the doctor at the next appointment without fail.

X_____

Parent/Legal Guardian Signature Date

Notes:_____

APPOINTMENT POLICY

At each appointment a portion of the doctor and staffs time is reserved specifically for your child. Any change in this appointment may affect our ability to effectively treat other patients in a timely manner. If a cancellation is unavoidable, please call our office **AT LEAST 24 HOURS** in advance so that we may give that time to another patient. Should you arrive late for your appointment it may be necessary to reschedule.

- ✓ Most restorative procedures (fillings, extractions, etc.) and procedures requiring medication are scheduled in the morning. Children, as well as adults, are more prepared and do better in the morning for these types of procedures.

- ✓ We strive to see all patients on time for their scheduled appointments. There are times when our schedule is delayed in order to accommodate a child with an urgent emergency. Please accept our apology in advance should this occur during your appointment.

- ✓ If 3 missed or cancelled appointments occur without 24-hours notice, we reserve the right to dismiss you from the practice or require a non-refundable deposit be made prior to scheduling.

FINANCIAL POLICY

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that *payment of your bill is considered a part of your child's treatment.*

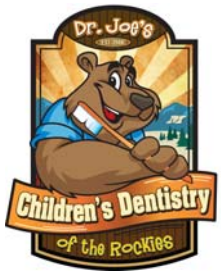
- ✓ Please be aware that the parent bringing the child to Children's Dentistry of the Rockies is *legally responsible for payment of all charges*. We cannot send statements to other persons without written consent from the guarantor.

- ✓ **No Dental Insurance -** Payment **is expected in full for each appointment as services are rendered.** For the convenience of our patients, we accept cash, personal checks (which cannot be postdated), and credit cards. We also offer Care Credit as another financing option. Those who pay with CASH or CHECK in full at the time of service will receive 5% discount.

- ✓ **Dental Insurance** – The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. We will file your insurance claim as a benefit to you, however you are responsible for the full balance including any amount that is not paid by your insurance company. We require a 20% payment at time of service for all work rendered except preventative services. The remaining balance will be billed to your insurance.

Occasionally an outstanding balance may occur in which case we require it to be paid in full within 30 days unless other arrangements have been made. We will not schedule future appointments until the balance on the account is paid in full. We reserve the right to apply a billing charge of $2.00 per month from the date of service. Should your account be sent to a collection agency a processing fee will be added to the balance. Thank you in advance for your understanding of our financial policy!

Parent/Legal Guardian Date



HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care options and for all other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. You have the right to request an electronic copy of your records if you prefer.

Uses and Disclosures of Protected Health Information(PHI)

Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law. Your PHI will not be used for fundraising or marketing purposes. In the event of a security breach we are obligated to inform you if your PHI is ever compromised.

Treatment

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In the event that you prefer to pay in full out of pocket for services, you have the right to request that we do not disclose treatment information for those services to a health plan.

Payment

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your dentist is ready for you to be seen. We may use or disclose your protected health information, as necessary, to contact you and to remind you of your upcoming appointments.

Required by Law

We may use or disclose patient health information when we are required to do so by law. Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Signature: _____ **Date:** _____

UPDATED: September 23, 2013