COLORADO
DENTISTRY FOR CHILDREN

New Patient Form

Child's Name:_____ Nickname:_____ Sex (M) (F)

Purpose of Visit:_____ Concerns:_____ Birthdate:_____

Child's Interests:_____ Name of Pet(s)_____

Does your child have any special needs?_____ Any Phobias?_____

Child's learning: slow average accelerated Child's School: _____

Who may we thank for referring you tous? _____

Health History

Child's Pediatrician:_____ Phone Number: (____)_____ Last Physical:_____

Is your child under a physician's care now? Y N If yes, reason: _____

Is your child currently taking any medications (including over the counter)? Y N If yes, please list: _____

Is your child allergic to any medication? Y N If yes, please list: _____

Any history of hospitalization or surgery? (If yes, when) _____

Does your child have an allergic reaction to: (please check all that apply)

_____Peanuts/Tree nuts	_____Soy	_____Latex/Rubber	_____Pollen/Dust/Environmental	_____Anesthetics
_____Eggs	_____Metals	_____Animals	_____Berries	_____Acrylic
_____Milk	_____Wheat/Gluten	_____Dyes/coloring	_____Others:_____	

Has your child had a history or difficulty with any of the following?

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hearing Impaired	Y N
AIDS/HIV	Y N	Cerebral Palsy	Y N	Hepatitis	Y N
Anemia	Y N	Chemo/Radiation Therapy	Y N	Immune Disorder	Y N
Allergies	Y N	Cystic Fibrosis	Y N	Kidney	Y N
Arthritis/Joint Disorder	Y N	Delayed Development	Y N	Liver	Y N
Asthma	Y N	Depression/Anxiety	Y N	Murmur	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down's Syndrome	Y N	Rheumatic Fever	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	Stomach/GI Problems	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cancer/Malignancy	Y N	Frequent Headaches	Y N	Visual Impaired	Y N

Other:_____

Dental History

Is this your child's first dental visit? Y N If no, previous dentist:_____ Phone number: (____)_____

Date of last visit:_____ How was his/her experience?_____ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: _____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe:_____

Has your child done any of the following (past or present)?
Please circle: thumb/finger-sucking pacifier use nail biting lip sucking mouth breathing snoring teeth grinding nursing bottle-feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N Does your child use fluoride toothpaste? Y N

How often does your child brush his/her teeth?_____ With adult supervision? Y N How often does your child floss? _____

How may we help to make this visit a positive experience for your child? _____

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General Information

Father (full name)_____SSN:_____Birthdate:_____Driver's License #: _____

Mother (full name)_____SSN:_____Birthdate:_____Driver's License #: _____

Parent(s) are: Married _____ Divorced_____ Single____ Widowed_____ Child lives with: both parents mother father other

Home Address:_____Home Phone: (_____)_____

Father's Employer:_____Cellular Phone: (_____)_____

Business Address:_____Work Phone: (_____)_____

Mother's Employer:_____Cellular Phone: (_____)_____

Business Address:_____Work Phone: (_____)_____

Email Address:_____Person financially responsible for child's dental care: _____

Emergency Contact:_____Address:_____Phone: (_____)_____

How would you like us to contact you? Home Work Cell E-mail

The permission of a parent or guardian is required before a minor can receive dental treatment. I hereby give permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE:_____Relationship:_____Date:_____

Insurance Information

Do you have dental insurance coverage for your child? Y N

Father's Insurance Company:_____Group Number:_____Phone: (_____)_____

Address of Father's Insurance Company: _____

Mother's Insurance Company:_____Group Number:_____Phone: (_____)_____

Address of Mother's Insurance Company: _____

Financial and Appointment Agreement

As a courtesy to our patients, we agree to bill your insurance company. The guarantor, however, is ultimately responsible for all balances due. Any charges not paid by an insurance company, ninety days from the date of service, will be billed to the guarantor, and payment is due upon receipt of the bill. Any payments made by the insurance company after the ninety day period will be credited to the patient's account. Those credited monies can then either be used towards future treatment, or the guarantor can request that a check be sent to his/her home address. Requested checks will be mailed no later than thirty days from the date of request. We will do our best in estimating how much an insurance company will pay towards a treatment plan, and then will present that information to each and every guarantor before scheduling a patient for treatment. These estimates are, by definition, only estimates however, and an adjustment may be necessary once we have been paid by the insurance company for benefits received.

By scheduling your child for treatment, you are expressly agreeing that you have been given an estimate of the cost of treatment, and are fully aware of your estimated portion, due and payable upon completion of treatment. Once the estimate is provided to the guarantor, it is the guarantor's responsibility to decide how he or she will pay for the outstanding balance the insurance will not cover at the time of treatment. We accept all major credit and debit cards for your convenience. Our appointment time is valuable; therefore, we require a 24 hour notice in the event a cancellation of a previously scheduled appointment is necessary. The office policy is that a patient and their siblings may be inactivated from the practice should there be two appointments of "no shows" or cancellations with less than 24 hours' notice.

SIGNATURE:_____Relationship:_____Date:_____

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INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES, TREATMENT FOR CHILD AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires health professionals to provide their prospective patients with information regarding the treatment or procedures they are contemplating. State law also requires us to obtain your consent to any specific dental treatment or techniques, which may be considered to be of concern to the patient or parent. Informed consent indicates your awareness of sufficient information to allow you to make informed personal choices concerning your child's dental treatment after considering the risks, benefits, and alternatives.

Please read this form and ask about anything you do not understand. We will be pleased to explain it to you.

Providing a high quality of care can sometimes be made very difficult or even impossible because of the lack of cooperation of some patients. All efforts will be make to obtain the cooperation of your dental patients by the use of persuasion, humor, gentleness and understanding. There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used behavior management techniques used in pediatric dentistry is as follows:

- **Tell-Show-Do:** The dentist or assistant explains to the child what is to be done using simple terminology and repetition and she shows the child whit is to be done demonstrating on a model or the child's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
- **Positive reinforcement:** The child is rewarded for displaying any desirable behavior. Rewards can be compliments, praise, or a prize.
- **Voice Control:** The attention of a disruptive child is gained by changing the tone of the dentist's or assistant's voice.
- **Mouth Prop:** A rubber or plastic device is placed in the child's mouth to prevent it from closing when a child refuses to open or has difficulty in maintaining an open mouth.
- **Passive Restraint:** A papoose blanket is used to keep the patient from making potentially dangerous, disruptive movements to enable the dentist to provide the necessary treatment.
- **Active Restraint:** The dentist, assistant, or parent holds the child's head, hands, and/or legs to keep them from injuring themselves or others.
- **Sedation:** Medication can be administered orally, by injection, or by gas to relax a child who does not respond to other behavior management techniques. This is a conscious sedation and can be mild, moderate, or deep levels.

Below is a list of dental procedures that may be performed on your child. A treatment plan will be made for your child and presented to you after the initial examination. Prior to each appointment the specific treatment that will be performed on your child that day will be explained to you.

1. **Diagnostic Procedures:** Examination, radiographs (x-rays) of the teeth & jaws, consultation, photographs, dental casts.
2. **Teeth Cleaning:** Removal of soft and hard deposits on teeth, and teeth polishing with special toothpaste.
3. **Fluoride Treatment:** A solution of fluoride is placed on teeth after cleaning. Fluoride hardens the surface of teeth and helps them resist tooth decay.
4. **Dental Sealants:** Plastic sealants are applied to the grooves of the chewing surface of newly erupted permanent molar teeth to help resist tooth decay.
5. **Local Anesthesia Injection:** "Numbing medicine" carefully used to numb the teeth and surrounding areas prior to certain dental procedures such as tooth removal and dental fillings
6. **Dental Rubber Dam:** A sheet of latex rubber used to carefully isolate the teeth that need dental treatment.
7. **Dental Fillings/Crowns:** Depending on the size of tooth decay, and location of tooth in the mouth, the following may be done. Front teeth: white filling/crown. Back teeth or canine teeth: silver amalgam filling or stainless steel crown.
8. **Pulp (tooth nerve) Treatment:** A procedure to save baby teeth and certain permanent teeth that would otherwise be lost because of a deep cavity that has affected the tooth nerve. Saving a baby tooth that would normally be expected to remain in the mouth for nine months or more is recommended because it provides the child with a chewing surface. Also, baby teeth serve as natural space maintainers for the adult teeth growing underneath them.
9. **Extraction (Removal) of Teeth:** Teeth may be removed because of infection, injury, orthodontic reasons (teeth

crowding), or if they are diseased and cannot be saved by any dental procedures.

10. **Space maintainer:** Recommended when baby teeth are lost prematurely. Helps maintain the natural space intended for a permanent tooth by preventing adjacent teeth from drifting together and forcing permanent teeth to erupt in a crowded condition.

The nature and purpose of the treatment and procedures have been explained to me in general terms by the dental staff of Destiny Dental. Alternate procedures or methods of treatment if any, have been explained to me. I have also had the advantages, disadvantages, risks, consequences and probable effectiveness of each explained to me, as well as the prognosis if no treatment is provided.

I am advised that though the results of the treatment are expected to be good, the possibility and nature of complications cannot be accurately anticipated for each individual. Therefore, there can be no guarantee as expressed or implied either of the result of the treatment or of the cure.

Risks and Complications: Although their occurrence is not frequent, some **risks and complications** are known to be associated with dental or oral surgery procedures. The **more common complications** associated with pediatric dental treatment include **nausea** following the administration of **topical fluoride** and children **biting** and **injuring** their **tongue or lip** following the administration of **local anesthesia. Less common complications** include the risks of numbness, infection, swelling, prolonged bleeding, discoloration of tissues, vomiting, allergic reactions, swallowing or aspiration of dental materials, an extracted tooth or gauze packing; injury to the tongue or lips, damage to and possible loss of existing teeth and or fillings, injury to nerves near the treatment site, and fracture of a tooth root which may require additional surgery for its removal. **For children with certain heart diseases, the risk of Infective Endocarditis (heart infection) following certain dental procedures exists.** Therefore, antibiotics will be prescribed before the treatment, to minimize the risk. I further understand and accept that complications may require additional medical, dental or surgical treatment that may require hospitalization.

I hereby acknowledge that I have read and understand this consent form. I have been given an opportunity to ask any questions that I might have. All questions about the procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions, which may arise during the course of my child's dental treatment. I also understand that I am free to withdraw my consent to treatment at any time. This consent shall remain in effect until I choose to terminate it.

Do you have any objections?_____Yes_____No

If yes, please explain? _____

By signing this consent form, I authorize and direct the dentists at Destiny Dental assisted by the dental staff of his/her choice, to perform upon my child (or legal ward for whom I am empowered to consent) the dental treatment or oral surgery procedures explained herein.

Today's date:_____ Time: _____

Patient's Name:_____ Date of birth: _____

Printed Name of person completing form_____Signature of person competing form_____

Your relationship to patient:_____Are you legally responsible for this child?_____Yes_____No

HIPPA Notice of Privacy Practices

This **Notice of Privacy Practices** describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. **Please review it carefully.**

Our Legal Duty: Federal and state law requires us to maintain the privacy of your protected health information. We are also required by law to give you this Notice and to abide by its terms while it is in effect. We reserve the right to change our privacy practices and terms of this Notice at any time. Before we make significant changes in our privacy practices, we will change this Notice and make it available upon request. This Notice takes effect June 11, 2014 and remains in effect until we replace it.

How We May Use and Disclose Your Protected Health Information:

When you receive our Notice of Privacy Practices, you will also be asked to sign an Acknowledgement of Receipt. Once you have received our Notice and signed the Acknowledgement, we will use your protected health information for treatment, payment and health care operations. The following are examples of how we typically use or share your health information:

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. We will also disclose protected health information to other professionals who may be treating 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 addition, we may disclose your protected health information from time-to-time to another health care provider (e.g., a specialist or laboratory) who, at the request of your dentist, becomes involved in your care by providing assistance with your health care diagnosis or treatment.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. You will however be able to restrict disclosures to your insurance carrier for services paid “out of pocket.”

Healthcare Operations: We may use or disclose your protected health information in order to run our practice and improve your care. Healthcare operations include quality assessment activities, employee review activities, licensing or credentialing activities, conducting training, conducting auditing, or other review activities.

Patient Communications: We may send you reminder postcards, text messages, emails, or telephone you to remind you of an appointment. We may also send you a newsletter about our practice and the services we offer. You may contact our office to request that these communications not be sent to you.

Business Associates: We may disclose your protected health information with third party Business Associates that perform services on behalf of our practice. Whenever we disclose your protected health information to a business associate, we will have a written contract that will protect the privacy of your protected health information. For example, we may share your health information with a billing company that helps us to obtain payment from your insurance company.

Family Members and Friends: Unless you object, we will disclose to your family member, a relative, a close friend or any other person you select, your protected health information to the extent necessary to help with your dental care or with payment for the services we have provided. We may also notify a family member, personal representative, or another person responsible for your care about your location or general condition. We will also use our professional judgment and common practice to make reasonable decisions in your best interest in allowing a person to pick up x-rays, prescriptions or similar forms of health information.

Disclosures That May Require Your Written Authorization: Any other uses and disclosures of your protected health information not mentioned herein will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization at any time, in writing, except to the extent that our office has already released your protected health information with your prior authorization.

Disclosures That May Be Made Without Your Authorization

Required By Law: We may use or disclose your protected health information if state or federal law requires us to do so. Under the law, we must make disclosures to you, and when required, to the Department of Health and Human Services when determining our compliance with privacy laws.

Abuse or Neglect: We may disclose your protected health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or that of other persons.

Public Health and Safety: We may disclose your health information for certain situations such as preventing disease, helping with product recalls, reporting adverse reactions to medications, and preventing or reducing a serious threat to anyone's health or safety. We can also use or share your information for health research.

Address Workers' Compensation, Law Enforcement, and other Government Requests: We can use or share health information about you for workers' compensation claims, law enforcement purposes, with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

Respond to Lawsuits and Legal Actions: We can share your health information in response to a court or administrative order, or in response to a subpoena.

Your Rights

Inspect and obtain a copy of your protected health information: You have the right to look at and make copies of your health information, with limited exceptions. You must make your request in writing. We will use a format you request unless we cannot practically do so. We will charge you a reasonable cost-based fee for expenses.

Receive a copy of this privacy notice: You can ask for a paper copy of this notice at any time.

Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will take reasonable steps to verify this.

Request a restriction of your protected health information: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement, except in an emergency.

Request alternative communication: You have that right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or the alternative location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Request a correction of your medical record: You have the right to request that we amend or correct your health information. Your request must be in writing. The request must explain why the information should be amended or corrected. We may deny your request under certain situations.

Receive an accounting of disclosures we have made of your health information: You have the right to an accounting of disclosures of your health information. This accounting will be for purposes other than treatment, payment or other health care operations, or disclosures we may have made to you, to family members or friends involved in your care. The right to receive this information is subject to some exceptions. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee.

Make a complaint about our privacy practices: If you are concerned that we have violated your privacy rights, you may file a complaint with us or with the Department of Health and Human Services by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201. We will not retaliate against you for making a complaint or change the way we treat you.

This Notice of Privacy Practices applies to the following organization:

Colorado Dentistry for Children, 242 Cambridge St, Brush, CO 80723

COLORADO
DENTISTRY FOR CHILDREN

Acknowledgement of Receipt of Notice of Privacy Practices

Section A: The Patient.

Name:_____ Age: _____

Section B: Acknowledgement by Patient or Legal Guardian.

I,_____, acknowledge that I have received a Notice of Privacy Practices from Colorado Dentistry for Children.

Signature:_____ Date: _____

Relationship to Patient: _____

Section C: To be completed by Staff

Our office made a good faith effort to obtain an Acknowledgement of Receipt of Notice of Privacy Practices but was unable to obtain it because:

1. Patient or legal guardian refused to sign
2. An emergency kept us from obtaining a signature
3. Language barriers prevented us from obtaining a

signature Name of Staff Member: _____

Signature of Staff Member:_____ Date: _____