All Seasons Dental, Inc.

2208 Thatcher Ave
Pueblo, CO 81004
(719) 545-3838
allseasonsdentalco.com

Patient Information

Welcome to All Seasons Dental! We appreciate you choosing to let us treat your child's dental needs. To assist us in providing your child quality service, please complete the following form. The information you provide us will remain strictly confidential. If you have any questions, please don't hesitate to ask!

Patient Information

Child's Name:_____ Gender : M F Age: _____

Nickname: _____ Social Security#:_____-_____-_____ Birthdate: _____/_____/_____

Home Address:_____

City: _____ State: _____ Zip: _____ Phone: (____)_____

School: _____ Grade:_____

Parent/Guardian Information

Mother/Legal Guardian's Name: _____

Address: (if different than child's) _____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Social Security #_____-_____-_____ Birthdate: _____/_____/_____ Cell Phone: (____)_____

Employer:_____

Occupation: _____ Work Phone:(____)_____

Father/Legal Guardian's Name: _____

Address: (if different than child's) _____

City:_____ State:_____ Zip:_____ Phone: (____)_____

Social Security #_____-_____-_____ Birthdate: _____/_____/_____ Cell Phone: (____)_____

Employer:_____

Occupation: _____ Work Phone:(____)_____

Name of parent/guardian who has *legal* custody: _____

Who does the child live with? ☐ Both Parents ☐ Mother ☐ Father ☐ Other: _____

Sibling Information

Name and ages of other children living in the household: (If more space is needed, please use the back of this form.)

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Dental Insurance Information

Primary Dental Insurance: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber #: _____

Secondary Dental Insurance: _____ Group #: _____

Subscriber's Name: _____ Date of Birth: _____

Subscriber #: _____

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Medical History

Child's Pediatrician: _____ Phone: (____) _____

Date of last physical exam: ____/____/____ Date of last pediatrician visit: ____/____/____

Reason for most recent visit to the pediatrician: _____

Has you child ever been hospitalized or had surgery? (Circle one) Yes No If so, when? ____/____/____

If so, why? _____

Are your child's immunizations for DPT (diptheria, whooping cough /pertussis, tetanus), polio, measles, mumps and German measles/rubella current? (Circle one) Yes No

Does your child have any of the following?

	Yes	No
Heart Problems		
Heart Murmur	☐	☐
Artificial Heart Valve	☐	☐
Rheumatic Fever	☐	☐
Pacemaker	☐	☐
Breathing Problems		
Asthma	☐	☐
Bronchitis	☐	☐
Difficulty Breathing	☐	☐
Bleeding Problems		
Hemophilia	☐	☐
Frequent Nose Bleeds	☐	☐
Ever Received a Transfusion	☐	☐
Intestinal Problems		
Gastric Reflux (GERD)	☐	☐
Neurologic Disorders		
Epilepsy	☐	☐
Seizures	☐	☐
Liver or Kidney Disorders		
Jaundice	☐	☐
Hepatitis	☐	☐
Endocrine Disorders		
Diabetes	☐	☐
Excessive Thirst	☐	☐

	Yes	No
Cancer or Tumor		
Diagnosed with cancer	☐	☐
Chemotherapy	☐	☐
Radiation	☐	☐
Surgery to Remove Tumor	☐	☐
Behavioral Concerns		
ADD/ADHD	☐	☐
Autism	☐	☐
Asperger's Syndrome	☐	☐
Allergies		
Hay Fever	☐	☐
Skin Rashes	☐	☐
Latex	☐	☐
Metals	☐	☐
Local Anesthetics (Novocaine)	☐	☐
Penicillin	☐	☐
Sulfa Drugs	☐	☐
Aspirin or Ibuprofen	☐	☐
Other Medications	☐	☐

Please list: _____

_____

_____

Medications: (Please list all medications your child is currently taking. If you need more room, use the back of this page.)

_____

_____

_____

Parent/Legal Guardian Signature: _____ **Date:** _____

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Dental History

General Information

What is the reason for your child's dental visit today? _____

Is this the first dental visit for your child? ☐ Yes ☐ No

Name of Previous Dentist: _____ Date of Last Visit: _____

Reason for Last Visit: _____

Date of last: Dental Exam: _____ Cleaning _____ Xrays _____ Fluoride Treatment _____

Has your child ever had an unfavorable dental experience? ☐ Yes ☐ No

If yes, please explain: _____

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Trauma/Injury to the Mouth or Teeth	☐ Crooked Teeth
☐ Toothache	☐ Gum Infections	☐ Jaw Sounds
☐ Sensitive Teeth	☐ Tooth/Teeth Changing Color	

Oral Health and Dietary History

How often does your child brush his/her teeth? _____ time(s) per _____.

	Yes	No		Yes	No
Does your child use dental floss?	☐	☐	Has your child ever taken a fluoride supplement?	☐	☐
Do you help your child brush his/her teeth?	☐	☐	Does your child drink tap water?	☐	☐
Does your child use a fluoride toothpaste?	☐	☐	Does your child drink bottled water?	☐	☐
Has your child ever had a fluoride treatment?	☐	☐			

Does your child snack between meals? ☐ Yes ☐ No If yes, list his/her preferred snacks: _____

_____

Does your child drink sugared beverages (ie: soda, kool-aid, juice, etc.)? ☐ Yes ☐ No

If yes, please list: _____

Habits

Does your child have a history of: (please check)

☐ Thumb/finger sucking	☐ Pacifier use	☐ Sleeping problems
☐ Lip biting or sucking	☐ Tongue thrusting	☐ Jaw pain/clicking
☐ Mouth breathing	☐ Mouth odor	☐ Biting hard objects
☐ Speech impediment/lisp	☐ Grinding teeth at night	☐ Snoring

Is there anything not covered on these forms you feel we should know about your child? _____

_____

_____

Parent/Legal Guardian Signature: _____ **Date:** _____

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HIPPA – Notice of Privacy Practice

HIPPA is a federal law developed to provide a standard for the protection of your health information. The purpose of this Notice of Privacy Practice is to explain how All Seasons Dental, Inc. may use or disclose your health care information. The Notice also explains the rights that you are guaranteed under HIPAA regulations.

Though All Seasons Dental, Inc. has always taken great care to protect the integrity and confidentiality of your health care information, we are now required by the HIPAA Privacy Rule to distribute this notice to you and obtain acknowledgment that you have received the Notice. I understand that by signing this consent I authorize All Seasons Dental, Inc. to use and disclose my protected health information to carry out:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers such as my insurance company.
- Conduct normal dental healthcare operation.

I have received, read and understand your Notice Of Privacy Practices containing a more complete description of uses and disclosures of my health information. I understand that All Seasons Dental, Inc. has the right to change its Notice Of Privacy Practices from time to time and that I may Contact this organization at any time at the address above to obtain a current copy of the Notice Of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand All Seasons Dental is not required to agree to my requested restrictions, but if they do agree then they are bound to abide by such restrictions. Under this law, All Seasons Dental, Inc. has the right to refuse to treat me, should I choose to refuse to disclose my Personal Health Information or if the restrictions I request will prevent adequate treatment or undue hardship on the practice.

If you have any questions, please contact our HIPAA Compliance Officer: Mary Aguilar.

I hereby acknowledge that I have received a copy of All Seasons Dental, Inc. Notice of Privacy Practices.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Permission to Bill Your Insurance

All services rendered are the responsibility of the patient. As a courtesy to you, All Seasons Dental, Inc. will file the necessary forms with your insurance carrier.

I understand my signature authorizes the release of my medical/dental information to my dental insurance company in order to facilitate their payment for services rendered. I also recognize I will be responsible for payment of all charges in full if I do not authorize All Seasons Dental, Inc. to release my protected medical/dental information to my insurance carrier.

Patient/Parent/Guardian Signature: _____ **Date:** _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices of All Seasons Dental, Inc. but was unable to do so because:

☐ Individual refused to sign.

☐ A communication barrier prohibited obtaining the acknowledgement.

☐ An emergency situation prevented us from obtaining acknowledgement.

☐ Other (Please specify): _____

Signature of Office Staff: _____ **Date:** _____

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Pediatric Informed Consent

Patient Name: _____ **Date:** _____

It is necessary for us to obtain your consent before performing your child's planned dental care. It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered for your child.

_____ **Dental Exam** **Parent/Guardian Initials:** _____

Because the caries process (cavities) can progress rapidly, it is important for your child to have regular exams. These allow us to monitor changes to your child's dental health and development so that any adverse changes can be noted and taken care of early when they are much easier to correct. A dental exam can also help us identify the orthodontic needs of your child, if any exist.

_____ **Dental X-rays** **Parent/Guardian Initials:** _____

X-rays are a very important because they allow us to see areas of the teeth that are not otherwise visible. Things like small cavities can be detected early when they are easier to treat. They also show how the permanent teeth are developing before they even come into the mouth. In some cases, x-rays can detect cysts and tumors. Dental x-rays are much safer today than ever before. With your child's health and safety in mind, we use a state-of-the-art digital x-ray system that uses very little radiation. To put this into perspective, the amount of radiation you are exposed to on an airplane ride from the east coast to the west coast is more than the amount we use to take our dental x-rays.

_____ **Dental Prophylaxis** **Parent/Guardian Initials:** _____

Dental prophylaxis (often called "teeth cleaning") is necessary to promote long term oral health habits. Brushing regularly at home is a good start but studies have found periodic professional cleanings provide better long-term prevention of gingivitis and gum disease. It also allows our team of dental professionals the opportunity to offer you and your child helpful hints on proper brushing and flossing techniques.

_____ **Fluoride Treatment** **Parent/Guardian Initials:** _____

Research has shown that fluoride reduces cavities in both children and adults. It also helps repair the early stages of tooth decay even before the decay becomes visible. Fluoride, like any other nutrient, is safe and effective when used appropriately.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the nature and purpose of the proposed treatment(s) for my child and I have received answers to my satisfaction. I understand the possible benefits and risks involved with this treatment as well as the risks associated with refusing treatment. No promises or guarantees have been made to me concerning the results. The fees for this service have been explained to me and are satisfactory. By signing this document, I am freely giving my consent to allow and authorize Dr. Craig and/or her staff to render the proposed treatment above for my child .

I understand that I may revoke this consent to treatment at any time and that this consent will remain in effect until such time that I choose to terminate it. If I choose to revoke this consent, no further action/treatment based on this consent will be initiated unless or until I give further authorization for treatment.

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

I hereby give the following persons permission to bring my child to All Seasons Dental, Inc. for their regularly scheduled recall appointments for the treatment(s) listed and for which I gave consent. I understand payment will be due on the date of service and I am responsible for payment even if the person/persons listed below brings the child to the appointment at my request and in my absence.

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Parent/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

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Financial Policy

Thank you for choosing All Seasons Dental for your dental needs. We are committed to providing you with excellent care and exceptional customer service. Our convenient financial arrangements are based on an open discussion of recommended treatment options, respective fees and your financial capabilities. Because we value you as a patient, we have worked diligently to find financial options that are rarely found at other dental offices. This Financial Policy is indicative of our respect for your right to know ahead of time what our expectations are of you in the area of finances.

Payment

Payment in full is due at the time of service unless prior financial arrangements have been made. We offer several payment options:

- Cash, Check, Visa, MasterCard or Discover card payments can be made at the time services are rendered.
- Monthly payment plans are available but may require a down payment, initiation fee and/or interest charges.

Insurance

The dental insurance contract is between you (the patient) and your insurance company. Therefore, you are responsible for the bill, regardless of the insurance coverage. As a courtesy to you, we will bill your insurance company; however, the responsibility for payment remains with you. Because insurance policies vary greatly, we can only estimate your coverage in good faith, but cannot guarantee it. In order for us to bill your insurance, you must supply our office with complete information about your coverage including, but not limited to, company name, employer and insurance group number. Insured dental patients are expected to pay the estimated non-insurance portion at the time of service as described above in the "Payment" section.

Payments and Billing

If your insurance has not paid within 60 days of treatment, you will be responsible for payment of the insurance balance. You will be reimbursed promptly if/when the insurance company remits payment to us unless you have an outstanding balance with our office in which case your unpaid portion will be subtracted from the total prior to issuance of the refund.

We mail monthly statements to all patients with an outstanding balance. Patients will be responsible for a $5.00 billing fee for any statement sent. Unpaid balances over 60 days will be assessed a finance charge of 18% per annum. In the rare instance an account with an unpaid balance becomes past due 90 days, the account will be sent to the collection agency. At that time, you will be responsible for any and all costs incurred in the collection of your debt.

Missed or Failed Appointment Policy

All Seasons Dental is careful in scheduling every appointment so that each patient receives their recommended treatment in a reasonable amount of time. In order to consistently provide this type of care, it is important for you to be on time for your appointments so we can keep our schedule running smoothly. Late or broken appointments prevent others from receiving the dental care they deserve. We understand that emergencies happen but we take missed appointments very seriously. We ask that you be considerate and inform us as quickly as possible if you need to change your appointment. When an appointment is cancelled with less than 48 hours notice or if the appointment is not honored, you may be charged a $50 missed appointment fee. If three appointments are cancelled without sufficient notice or are missed, you may be dismissed from the practice. If you move or change phone numbers and do not inform our office, we may be unable to contact you in order to confirm your appointment. In such an instance, your appointment time will not be held for you.

Treatment of Minors

Consent for treatment by a parent of legal guardian is required when treating a minor child. In some cases, you can sign a consent form for us to keep on file. This is helpful when the patient is over 16 and is a licenses driver. All Seasons Dental retains the right to refuse to treat a minor child if the proper consenting adult is not present for the dental appointment. We also require that the adult remain on the premises during the entire treatment. In the case of divorce or separation, the parent authorizing treatment for the child(ren) will be the parent responsible for that day's charges. We do not get involved with divorce specifics. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the parent's obligation to work out an agreement themselves or through the court system.

By signing below, I acknowledge I have read and understand the "Financial Polices" of All Seasons Dental. I also acknowledge having had the opportunity to have my questions about these policies answered prior to signing.

Patient/Parent Signature: _____ **Date:** _____