GVK
GREEN VALLEY KIDS
PEDIATRIC DENTISTRY

PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PATIENT OR PARENT'S EMPLOYER _____

BUSINESS ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

IF PT IS A STUDENT, NAME OF SCHOOL _____

CITY _____ **STATE** _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

CONFIDENTIAL

BIRTHDATE _____

HOME PHONE _____

CIRCLE APPROPRIATE SELECTION:

MALE FEMALE

WORK PHONE _____

CELL PHONE _____

OTHER _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT
_____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

EMPLOYER _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

EMAIL:_____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

BIRTHDATE _____

SS NUMBER _____

CIRCLE APPROPRIATE SELECTION:

MINOR SINGLE MARRIED

DIVORCED WIDOWED SEPERATED

INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER _____

INSURANCE PHONE _____

Medical History Form

Directions: Please circle appropriate answers and fill in blanks
If you don't know an answer circle "(?)"
Please complete the front and back

Medical History

Does the Patient have any history of the following?
Heart problems or murmur..... YES NO (?)
Rheumatic fever..... YES NO (?)
Bleeding or clotting problems..... YES NO (?)
Sickle cell or anemia or trait..... YES NO (?)

Cleft lip or palate ..... YES NO (?)
Birth defects or genetic disorders ..... YES NO (?)
Epilepsy or seizures..... YES NO (?)
Mental Retardation..... YES NO (?)

Growth problems..... YES NO (?)
Cerebral Palsy..... YES NO (?)
Ear or hearing problems..... YES NO (?)
Speech difficulties..... YES NO (?)

Vision problems..... YES NO (?)
Asthma or wheezing..... YES NO (?)
Allergies (hay fever, Laytex sensitivity, etc.)..... YES NO (?)
Feeding or eating disorders..... YES NO (?)

Hepatitis or liver disease..... YES NO (?)
Diabetes..... YES NO (?)
Tuberculosis..... YES NO (?)
Kidney Problems..... YES NO (?)

Bone or joint problems..... YES NO (?)
Drug or alcohol use..... YES NO (?)
Smoking or use of snuff or smokeless tobacco..... YES NO (?)
Sexually transmitted or venereal disease..... YES NO (?)

AIDS or AIDS-related complex..... YES NO (?)
Cancer..... YES NO (?)
Other medical problems (specify)_____ _YES NO (?)

Name of patient's physician _____ Date of last visit _____
Address _____ Phone _____

Is the patient currently under the care of a physician?..... YES NO (?)
If yes, for what condition..... YES NO (?)
Is the Patient currently taking any medications..... YES NO (?)
If yes, list _____
If yes, for what condition _____
Has the patient had any allergic or unfavorable reaction to any medications?
To what _____reaction _____
Has the patient ever been hospitalized _____

Age _____ Reason _____
Has the patient been treated in the emergency room? ..... YES NO (?)
Age _____ Reason _____
Are the patient's immunizations up-to-date? ..... YES NO (?)
Is the patient pregnant at this time?..... YES NO (?)
Is there any additional medical information about the patient not reported above?..... YES NO (?)
If yes, please describe_____

DENTAL HISTORY

Why is the patient seeking dental care? _____
Is this the patient's first visit to a dentist? ..... YES NO (?)
If no, give the date of last visit _____
Has the patient had any of the following dental problems?
Injuries to the mouth or teeth..... YES NO (?)
Toothaches/pain ..... YES NO (?)
Abscesses..... YES NO (?)
Other (specify)_____
Does the patient have any of the following habits?
Finger or thumb sucking? ..... YES NO (?)
Tooth grinding or clenching? ..... YES NO (?)
Other (specify _____
At what age was the bottle or breast feeding stopped? _____
What is the source of the patient's current drinking water supply?
_____City _____Home Well _____Bottled _____Don't Know
Is this water Fluoridated? ..... YES NO (?)
Does patient receive fluoride tablets, drops or vitamins with fluoride? ..... YES NO (?)
Does the patient use a fluoride rinse at home or school? ..... YES NO (?)
Who is responsible for brushing the patient's teeth? _____
Is there any additional information we should know? ..... YES NO (?)
If yes, please describe _____

SOCIAL AND BEHAVIORAL HISTORY

Do you think the patient will cooperate for dental treatment? ..... YES NO (?)
Has the patient had a bad or fearful dental or medical experience? ..... YES NO (?)
Which of the following best describes the patient?
_____Advanced in the learning process _____Progressing normally _____Slow learner
Does the patient have any history of emotional or behavioral problems? ..... YES NO (?)
If yes, please describe _____
Are there any cultural, religious or ethnic concerns that could affect the care of the child? YES NO (?)
If yes, please describe _____
Names and ages of other children in the family _____
Is there any additional information we should know? ..... YES NO (?)
If yes, please comment _____

To the best of my knowledge the above information is correct.

_____ _____ _____
Signature of parent Date Relationship to Patient

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OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve you in a comfortable and professional atmosphere. Our goal is to provide you with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT. For treatment involving fees above $500.00, special financial arrangements may be discussed with our financial coordinator or office administrator.

- For patients with Dental Insurance:
  Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
  - We will file your claim for you at no charge; however, we ask that your deductibles and your estimated portions (20%-60%) be paid as services are rendered. Although we gladly file dental insurance claims as a courtesy to you, any and all account balances are ultimately your responsibility.
  - Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
  - All insurance policies that the patient is covered under must be given to us the day of the appointment. Should the patient be covered by additional insurance that was not made known the day of his/her appointment and you'd like us to submit the claim to that company, a $75 re-processing fee will be assessed.
  - All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.
- Please note, for your convenience, we do accept VISA and MasterCard, as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for you. We ask for the courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we require a 24-hour notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $75.00, or no reappointment. If more than one family member is scheduled & fails to make their appointment a $75 cancellation fee will be assessed for the first individual and $50 for each family member thereafter. This policy is strictly enforced due to our high volume of patients.**
- Our office will provide confirmation calls and postcards to you. We ask that if we are unable to reach you, that you please contact us as soon as possible to confirm you appointment. Failure to do so may result in your appointment needing to be rescheduled.
- We realize that many families are in a state of change. The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.
- We will be fair in working out special finances with you, but please also be fair to us with your commitments. A 1.5% finance charge will be assessed monthly on all overdue balances.
- All collection fees, court costs, reasonable attorney fees or returned check fees are the responsibility of the adult person(s) named on the account.
- Treatment appointments made that **exceed $500.00 will require 10% down** to hold the appointed time.

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Signature _____(Patient, Parent or Guardian)

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Green Valley Kids

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 303-371-4485.

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Green Valley Kids does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. *Safeguarding Your Personal*

and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Green Valley Kids maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Green Valley Kids.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Green Valley Kids occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I _____ have reviewed Green Valley Kids Privacy Policy.

Signed_____Date_____

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Notice and Consent Form

Patient Name:_____

Parent's Name:_____

Green Valley Kids wants you and your child's visit to be both educational and enjoyable. Therefore, we request that you read this **Consent and Notice Form** carefully.

This form is meant to provide information on some of the routine procedures we perform. If you do not have any questions or concerns we ask that you complete the form and sign the bottom of the page giving us your consent to perform the listed procedures if deemed necessary.

Please place a √ next to each box indicating that you understand and consent to the procedure:

☐ Consent to receive dental treatment: I consent and authorize Dr. Roberts and his employees to examine, clean, and provide dental treatment for my child. I further consent and authorize the taking of dental x-rays, as may be considered necessary, by Dr. Roberts to diagnose and/or treat my child. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes.

☐ Consent to receive Nitrous Oxide/Oxygen Sedation: I consent and authorize Dr. Roberts to use, if deemed necessary, Nitrous Oxide (laughing gas) during the treatment of my child. Nitrous oxide/oxygen sedation is a generally safe and effective technique to reduce or eliminate anxiety and enhance effective communication. Its onset is rapid. The depth of sedation is easily titrated and reversible, and recovery is rapid and complete. Additionally, nitrous oxide aids in analgesia (reducing pain) and reducing the gag reflex.

☐ Consent to immobilization: I understand and agree that it may be necessary for Dr. Roberts to use a papoose board (hug blanket) during the dental procedure to prevent injury and enable him to safely provide the necessary treatment for my child.

Date:_____ Parent/Guardian's Signature: _____

Date _____ Witness Signature _____

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AUTHORIZATION TO TREAT A MINOR

I, as the Parent/Guardian of _____ am legally able to make all medical/dental decisions for said child. I understand that by signing this form, all responsibility, for consenting to proposed and performed treatment is my decision, and I do not legally need to consult anyone else in order to authorize treatment of _____.

I am authorizing the following person(s) to consent to dental treatment in the event I cannot attend a dental appointment.

_____ _____

NAME OF AUTHORIZED PERSON RELATIONSHIP

_____ _____

NAME OF AUTHORIZED PERSON RELATIONSHIP

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____

WITNESS SIGNATURE **DATE**