Colville Pediatric Dentistry

COLVILLE PEDIATRIC DENTISTRY PATIENT REGISTRATION

Colville Pediatric Dentistry complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We will take reasonable steps to provide free-of-charge language assistance services to people who speak languages we are likely to hear in our practice and who don't speak English well enough to talk to us about the dental care we are providing.

Colville Pediatric Dentistry cumple con las leyes federales de derechos civiles aplicables y no discrimina. por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.

PATIENT INFORMATION

First Name:		Last Name:
Mailing Address:		City/State/Zip:
Date of Birth:	Sex:	Preferred Name:
Preferred Language:		How did you hear about us?:

GUARDIAN INFORMATION

Guardian (1) Name:	Guardian (2) Name:
Guardian (1) Date of Birth:	Guardian (2) Date of Birth:
Guardian (1) Phone Number:	Guardian (2) Phone Number:
Guardian (1) Email:	Guardian (2) Email:
Relationship to Patient:	Relationship to Patient:

WHO HAS LEGAL CUSTODY OF PATIENT? Guardian 1 ___ Guardian 2 ___Other_____

EMERGENCY CONTACT: Name _____ Relationship _____ Phone Number: _____

NON-PARENT(S) PERMITTED TO BRING PATIENT

I affirm that I am the parent or legal guardian of the above-named minor. If I am unable to accompany my child, I give permission for the individuals named below to escort my child to their dental appointment(s) and consent to treatment(s). This does **NOT** include any oral sedation/ general anesthesia procedures.

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Legal Guardian Signature: _____**Date:**_____

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MEDICAL HISTORY

Child's Pediatrician/Office Name: _____ Approximate Date of Last Exam _____

Has your child ever been admitted to the hospital or had surgery? Yes ____ No ____

If yes, please list: _____

Does your child have any allergies? Yes ___ No ___ *If yes, please check all that apply and specify:*

- ○ Food _____
- ○ Medications _____
- ○ Latex _____
- ○ Local Anesthetics _____
- ○ Other _____

Does your child take any medications? Please list:

_____

Does your child have any of the following conditions? *Check all that apply:*

○ Asthma	○ Heart Murmur	○ Fainting/Dizziness	○ Speech Delay
○ Autism	○ Diabetes	○ Liver Disease	○ Developmental Delay
○ Bleeding Problems	○ Thyroid Problems	○ Psychiatric Problems	○ Kidney Disease
○ Blood Transfusions	○ Seizures/Epilepsy	○ Tuberculosis	○ ADD/ADHD
○ Heart Conditions	○ Muscular Disorder	○ HIV/AIDS	

Other Condition(s): _____

Please list any special needs or concerns regarding your child: _____

Is your child up to date with immunizations? Yes _____ No _____

DENTAL HISTORY

Is this your child's first dental visit? Yes _____ No _____

Previous Dentist? _____ Approximate Date of Last Exam:_____

Has your child had previous dental trauma? Yes _____ No _____

If "yes", please explain: _____

Has your child had a previous bad experience at the dentist? Yes _____ No _____

If "yes", please explain: _____

Does your child use any fluoride products? Toothpaste ___Drops ___Water ___ Tabs ___ None ____

Does your child have any oral habits? Thumb Sucking ___ Grinding ____ Tongue Thrust ____ Lip Biting ____

Has your child had any of the following before? Cavities ___ Fillings ___ Crowns ___ Extractions ___

Has your child had an orthodontic evaluation or treatment? Yes ____ No ____

Name of orthodontist: _____

Preferred Pharmacy : _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services my child may need.

Legal Guardian Signature: _____ Date: _____

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INSURANCE AND FINANCIALS

We bill your insurance as a courtesy to you. It is your responsibility to be familiar with your plan coverage, limitations, copays etc. We advise that you follow up with your insurance carrier on any claims unpaid after 90 days from date of service. As consistent with applicable laws and the terms of your insurance or other plan coverage, CLAIMS THAT ARE NOT PAID FOLLOWING 90 DAYS FROM DATE OF SERVICE will become patient responsibility for payment.

- **Primary Insurance:**

Insurance Company:	
Subscriber Name:	Subscriber DOB:
Subscriber ID:	Subscriber SSN:
Subscriber Employer:	Group Number:

- **Secondary Insurance:**

Insurance Company:	
Subscriber Name:	Subscriber DOB:
Subscriber ID:	Subscriber SSN:
Subscriber Employer:	Group Number:

- **State Insurance:** _____
- **No Insurance:** For our patients without insurance, we offer a cash pay discount. Be prepared to pay at time of service.

I hearby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information, for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment, and (5) my dentist's use of records for scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

Legal Guardian Signature: _____Date: _____

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CONSENT AND PRIVACY STATEMENT

I, _____, attest that I am the legal guardian of the below listed names and authorize Dr. Patrick Bradley, DDS and any associated dentist, hygienist, or assistant to provide routine and emergency dental care for my child/children.

LIST EACH CHILD'S NAME: _____

PLEASE INITIAL EACH PARAGRAPH:

- Authorization is given for: examinations, X-Rays, cleanings, fluoride, administration of local anesthetic and nitrous oxide, and routine restorative treatment, including: fillings, crowns, pulpal therapy, space maintenance, and primary tooth extractions> _____
- I understand the behavior of children in the dental office can be unpredictable and authorize Dr. Bradley and associates to employ the use of a mouth prop and brief periods of physical restraint* to ensure the safety of my child. _____

  (Colville Pediatric Dentistry will **NEVER** use "medical restraints" in the forms of papoose boards, pedi-wraps, tape, straps, ets.)
- I understand the Notice of Privacy Practices is available to me by request. I understand this policy describes the types of uses and disclosures of my protected health information that may occur in relation to treatment, referrals, payments, or other health care operations. I also understand that this policy details my rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) _____

  (Please notify Colville Pediatric Dentistry if you would like a copy of the Notice of Privacy Practices for your records)
- I authorize my pediatrician and/or other physicians/medical facilities to release any and all pertinent medical information/records regarding my child and give Colville Pediatric Dentistry permission to release medical information/records to other physicians/medical facilities if needed. _____

INFORMED CONSENT TO PHOTOGRAPH

Colville Pediatric Dentistry is proud of your child for doing an outstanding job keeping their teeth clean and we enjoy recognizing their accomplishments! In honor of their good dental habits, we might like to display their photo on our "Cavity Free Kids" wall, clinic brochures and/or clinic advertising, website, as well as our Colville Pediatric Dentistry Facebook and Instagram pages. Colville Pediatric Dentistry will protect the patient's personal data such as name, age, and date of birth from being displayed.

I give consent to use my child's photograph on:

- "Cavity Free Kids" Wall
- Facebook/ Instagram
- Colville Pediatric Dentistry's website
- Clinical brochures/ Marketing materials
- I **DO NOT** give consent to use my child's photo for any of the above purposes

Legal Guardian Signature: _____ Date: _____

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INSURANCE AND APPOINTMENT POLICIES

INSURANCE POLICY: in an effort to keep costs down while maintaining a high level of professional care, we file insurance claims as a courtesy to our patients provided you agree to the following:

- You must provide us with an insurance card and all necessary information to verify your child's coverage to file your claim.
- Patients with insurance will be required to pay, at time of service all estimated portions. This payment is an **estimate** by our office based on your insurance benefits. We are not responsible for its accuracy. **It is ultimately your responsibility to be familiar with your plan's benefits, limitations, exclusions, etc.** Receiving our services indicates your acceptance of responsibility to pay regardless of our estimate.
- You are responsible for deductibles, co-payments, coinsurance, and any balance remaining in your account not covered by insurance.
- Your insurance policy is a contract between you, your employer, and the insurance company. Wea re not a party to that contract. All dispute resolutions will be with your insurance company.
- After dental insurance has paid its portion, a statement will be sent to the mailing address on record for remaining balance.

PAYMENT/FEE POLICY: Payment is due at the time of service. Our office accepts cash, check, Visa, and MasterCard. **Any account which is past due more than 180 days is subject to dismissal of the family from the practice and subject to being referred to an attorney for collection.** Additional fees may be applied to your account as follows:

- $30 charge for all returned checks
- $40 missed/broken appointment (see definition of broken appointment)
- Appliance fee for no-show/broken appointment or broken appliance (dependent on the lab charge)

GENERAL ANESTHESIA APPOINTMENTS-SURGICAL POLICY:

- If you "no-show" to your child's scheduled general anesthesia (GA) appointment, depending on your insurance, you will be charged a fee of $100.00 and this will result in the dismissal of your child from the practice.
- **IF YOU CANNOT ATTEND YOUR SCHEDULED GENERAL ANESTHESIA APPOINTMENT:** You must call to reschedule a minimum of one week (7 days, excluding holidays/weekends) in advance to cancel. If we do not have one week advance notice of cancellation, depending on your insurance, you will be charged a fee of $100.00. We will not reschedule the GA appointment until the fee is paid. This is considered a "broken" GA appointment. We only reschedule your child's GA appointment one additional time after the fee is paid. If a second "broken" GA appointment occurs, depending on your insurance, you will be charged a $100.00 fee and the second "broken" GA appointment will result in the dismissal of your child and family from the practice.
- If we do not receive the required pre-surgical physical within the date range specified, your child's appointment will be cancelled. It is your responsibility to call our office to get back on our schedule for surgery if this happens. Once scheduled for the second time, if you fail to get the required pre-surgical physical by the deadline, your family will be dismissed from the practice and treatment will not be rescheduled.
- We realize that sometimes sickness can come on very quickly, so we ask that you contact us immediately and schedule your child for a wellness evaluation prior to the procedure.

ORAL SEDATION APPOINTMENT POLICY:

- **NO-SHOW TO ORAL SEDATION APPOINTMENT:** If you "no-show" to your child's oral sedation appointment, depending on your insurance, you will be charged a fee of $100.00 and this will result in the dismissal of your family from the practice.
- **IF YOU CANNOT ATTEND YOUR CHILD'S SCHEDULED ORAL SEDATION APPOINTMENT:** You must call 3 days (72 hours, excluding holidays/weekends) in advance to cancel. If we do not have a 3 day advance notice of cancellation, depending on your insurance, you will be charged a fee of $100.00. we will not reschedule the oral sedation appointment until the fee is paid. This is considered a "broken" appointment. We will only reschedule your child's oral sedation appointment one additional time after the fee is paid. If a second "broken" appointment occurs, depending on your insurance, you will be charged a fee of $100.00 and the second broken oral sedation appointment will result in the dismissal of your child and family from the practice.
- We realize that sometimes sickness can come on very quickly, so we ask that you contact us immediately and schedule your child for a wellness evaluation prior to the procedure.

LATE ARRIVAL POLICY: We ask that you check in to your child(ren)'s scheduled appointments 15 minutes early. If you arrive more than **15 minutes** later than the check in time, you are considered late and we may need to reschedule to a different day.

BROKEN & MISSED APPOINTMENT POLICY:

Your child's scheduled appointment is reserved specifically for them. We have text messages/emails that go out two weeks prior, 3 days prior, and two hours prior to ensure you are aware of appointment times. It is your responsibility to keep your phone number current with our office.

- No showing or cancelling within the 24 hour period will result in a **BROKEN APPOINTMENT.**
- **IF MORE THAN TWO BROKEN APPOINTMENTS OCCUR AS A FAMILY, YOUR FAMILY WILL BE DISMISSED FROM THE PRACTICE.**
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Legal Guardian Signature: _____ **Date:** _____