PATIENT'S NAME_____
Last First Initial Date of Birth

PATIENT'S NAME_____
Last First Initial

COMMENTS (Include date, details, initials)

DENTAL HISTORY

1. Is this the child's first visit to a dentist?.....YES NO
2. If not, how long since the last visit to he dentist?_____
3. When was the last time the teeth were cleaned?_____
4. Does child eat between meals?.....YES NO
5. Does child eat sweets (candy, soda pop, chewing gum)?.....YES NO
6. Does child eat well balanced meals?.....YES NO
7. Does child brush teeth upon rising?.....YES NO
   - When going to bed?.....YES NO
   - Right after eating meals?.....YES NO
   - After eating any food?.....YES NO
8. Do you live in area without fluoridated water?.....YES NO
9. Have teeth been treated with fluoride?.....YES NO
10. Have any cavities been noted in the past?.....YES NO
11. Were any teeth (baby or permanent) removed by extraction?.....YES NO
    - Was it suggested that the space be maintained?.....YES NO
    - Was an appliance placed?.....YES NO
12. Have there been any injuries to teeth (falls, blows, chips, etc.)?.....YES NO
    If so, describe._____
13. Has child had any unfavorable dental experiences?.....YES NO
14. How many children in your family?.....YES NO
15. Has anyone in the family, including parents, had orthodontics?.....YES NO
16. Has child ever received a local anesthetic or any form of anesthetic?..YES NO
17. Has child ever had occlusal sealants?.....YES NO

MEDICAL HISTORY

1. Is child in good health?.....YES NO
2. Is child under care of physician?.....YES NO
   If yes, since when?_____ Why?_____
   _____
3. Name of physician?_____
4. Is child receiving any medication?.....YES NO
   When?_____ Why?_____
5. Has the child had any serious illness?.....YES NO
   When?_____ Why?_____
6. Is the child allergic to penicillin, antibiotics, other drugs?.....YES NO
7. Does the child have any other allergies?.....YES NO
8. Has child had surgery?.....YES NO
9. Is surgery planned?.....YES NO
10. Is child subject to excessive bleeding?.....YES NO
    - Fainting?.....YES NO
    - Dizziness?.....YES NO
11. Has child had history of: (circle appropriate responses) diabetes, heart trouble asthma, kidney infection, rheumatic fever, toothache, ear infection.

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S SIGNATURE_____ DATE_____

DENTIST'S SIGNATURE_____ DATE_____

CHILD DENTAL & MEDICAL HISTORY

PATIENT INFORMATION
(Person being seen for visit)

NAME_____
Last First Initial

HOW DO YOU WISH TO BE ADDRESSED_____

CIRCLE: Single Married Divorced Widowed Minor GENDER: Male Female

Social Security #_____Date of Birth_____ Age_____

ADDRESS—STREET_____

CITY_____STATE_____ZIP_____

PHONE: HOME_____WORK_____CELL_____ Drivers Lic.#_____

BEST TIME TO CALL_____EMAIL_____

GUARANTOR INFORMATION
(Person responsible for the account)

NAME_____
Last First Initial

CIRCLE: Single Married Divorced Widowed Minor GENDER: Male Female

Social Security #_____Date of Birth_____ Age_____

ADDRESS—STREET_____

CITY_____STATE_____ZIP_____

PHONE: HOME_____WORK_____CELL_____ Drivers Lic.#_____

BEST TIME TO CALL_____EMAIL_____

EMPLOYMENT INFORMATION FOR GUARANTOR

NAME OF EMPLOYER_____ADDRESS_____

CITY_____STATE____ZIP_____PHONE_____FAX_____

REGISTRATION

EMERGENCY INFORMATION
(Someone to notify in case of emergency)

NAME_____

ADDRESS_____

PHONE: HOME_____WORK_____CELL_____

REFERRAL INFORMATION
(Whom may we thank for this referral)

NAME_____ADDRESS_____

____yellow pages ____benefits manager ____insurance co. ____direct mail ____internet

Other_____

PRIMARY DENTAL PLAN/INSURANCE

NAME OF DENTAL PLAN/INSURANCE_____

ADDRESS TO SEND CLAIMS (if applicable) _____

CITY_____STATE_____ZIP_____PHONE_____

NAME OF INSURED SUBSCRIBER_____

CIRCLE RELATIONSHIP TO SUBSCRIBER: Self Spouse Child

POLICY/GROUP NUMBER_____INSURED'S SS# OR ID#_____

SECONDARY DENTAL PLAN/INSURANCE

NAME OF DENTAL PLAN/INSURANCE_____

ADDRESS TO SEND CLAIMS (if applicable) _____

CITY_____STATE_____ZIP_____PHONE_____

NAME OF INSURED SUBSCRIBER_____

CIRCLE RELATIONSHIP TO SUBSCRIBER: Self Spouse Child

POLICY/GROUP NUMBER_____INSURED'S SS# OR ID#_____

REGISTRATION

RELEASE

1. I authorize the dentist to perform diagnostic procedures and treatment as may be deemed necessary for proper dental care.
2. I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment to another dentist.
3. I authorize the dental group and/or its agents to transmit patient billing and/or insurance information to my insurance carrier electronic communication address in lieu of U.S. Postal Service.
4. I authorize the dental group to communicate through the use of electronic mail; appointment reminders, bills and other financial information, unfinished treatment plans which may contain information related to health issues identified by my dentist during previous appointments, and any other necessary information related to my dental treatment that my dentist believes necessary. I am providing the e-mail address listed below for that purpose. I understand that it is my responsibility to notify my dentist when my e-mail address changes as soon as is practical. I understand that e-mail is being used for my convenience and privacy and improved efficiency in communicating with my dentist. I will not hold the dentist responsible for disclosures that occur due to other individuals reading e-mails sent to the address provided below
5. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services.
6. I understand that I am financially responsible for payments in full of my dental account.
7. By signing this statement, I agree to be responsible for payment of services not paid, in whole or in part, by my dental plan payer.

_____ _____

Patient's or Guardian's Signature Date

SIGNATURE ON FILE

Dental Health Centers is authorized to provide any insurance company, administrator, and consulting health care professional, information concerning health care advice, treatment or supplies provided. This information will be used for the purpose of evaluating and administrating claims for benefits. This authorization is valid for the term of coverage of the policy or contract in force on this date only. I know I have the right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

Patient's or Guardian's Signature

I hereby authorize payment directly to Dental Health Centers of the dental benefits otherwise payable to me.

Insured's Signature

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to disclose and use protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing, at any time. However, any use or disclosure that occurred prior to this date I revoked this consent, is not in effect.

Signed this date: _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Practice Name: _____

For Office Use Only

We attempted to obtain written acknowledgement of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- ❑ Individual Refused to Sign
- ❑ Communication barriers prohibited obtaining acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____
_____

Greeley Dental Health Financial Policy

We would like to take this opportunity to welcome you to our office and assure you that we will do our utmost to provide you with the best care possible. We also would like to explain our financial policy as it relates to your responsibility for the account.

Patients without Insurance Coverage
Patients without insurance coverage are requested to pay for services as rendered. We accept personal checks, cash, AMEX, Discover, Mastercard and Visa.

Patients with Insurance Coverage
Our office will be glad to help you obtain the appropriate benefit from your insurance carrier as a courtesy to you. However, you are responsible for the payments on the account.

We do our best to provide you with an estimate of the co-insurance payment by you. However any balance not paid by the insurance company will be your responsibility unless stated by your carrier. Even if you have dual coverage (this is possible if you and your spouse both have insurance), there may still be a portion that will be your responsibility.

If you are having treatment over a period of time, we would appreciate payment during the course of treatment. Our office manager will assist you in arranging a payment schedule.

Additional Terms
Customer hereby acknowledges and agrees that any account that becomes delinquent will be subject to collections service. Customer agrees to pay all court costs and reasonable attorney fees for collection of all past due amounts owed, plus interest thereon at 18% (eighteen percent) per annum on all such amounts outstanding. There will also be a $35 service charge on all returned checks and additional charges for cost of collection.

Finally, be assured that we are all here to serve you with the best care possible. When leaving our office, you should leave with the feeling that all your questions have been answered.

I HAVE READ THE ABOVE AND UNDERSTAND THE FINANCIAL POLICY OF GREELEY DENTAL HEALTH.

_____ _____

Signature of Patient or Guardian Date