

PATIENT REGISTRATION

| | |
|------------------------------|---|
| PATIENT | Full Name: _____ Preferred Name: _____ Birthdate: _____ Gender <input type="checkbox"/> M <input type="checkbox"/> F Child Lives With: <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other: _____ |
| PARENT LEGAL GUARDIAN | _____ Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other: _____ Full Name: _____ Preferred Name: _____ Home Address: _____ City _____ State _____ Zip _____ Home Phone: _____ Cell _____ Work _____ Best? _____ Email Address: _____ Occupation: _____ Birthdate: _____ Social Sec. # _____ - _____ - _____ Driver's Lic. # _____ State _____ |
| PARENT LEGAL GUARDIAN | _____ Mother <input type="checkbox"/> Father <input type="checkbox"/> Stepmother <input type="checkbox"/> Stepfather <input type="checkbox"/> Grandmother <input type="checkbox"/> Grandfather <input type="checkbox"/> Other: _____ Full Name: _____ Preferred Name: _____ Home Address: _____ Apt _____ City _____ State _____ Zip _____ Home Phone: _____ Cell _____ Work _____ Best? _____ Email Address: _____ Occupation: _____ Birthdate: _____ Social Sec. # _____ - _____ - _____ Driver's Lic. # _____ State _____ |

Parents Marital Status: Married Partnered Divorced Separated Widowed Single

| |
|--|
| Emergency Contact Person (Other than parents/legal guardians above) Name: _____ Relationship: _____ Best Phone # _____ |
| May we thank anyone for referring you to us? Pediatrician: _____ Dentist: _____ Friend: _____ Family: _____ Internet: _____ Other: _____ Drive-by: _____ |

Primary Insurance Information

Policy Holder's Name: _____
 Birthdate: _____
 Employer: _____
 Social Sec # _____ - _____ - _____
 Member ID # _____
 Relationship to patient:
 Parent Self Other: _____

Insurance Company: _____
 Insurance Phone # _____
 Group Number: _____
 Policy Number: _____

If your child carries CHP+ or a purchased individual plan, your child's SSN and ID # are required to submit the claim to your insurance co.

Secondary Insurance Information

Policy Holder's Name: _____
 Birthdate: _____
 Employer: _____
 Social Sec # _____ - _____ - _____
 Member ID # _____
 Relationship to patient:
 Parent Self Other: _____

Insurance Company: _____
 Insurance Phone # _____
 Group Number: _____
 Policy Number: _____

Children in household (Other than patient)

_____ DOB _____
 _____ DOB _____
 _____ DOB _____
 _____ DOB _____
 _____ DOB _____
 _____ DOB _____
 _____ DOB _____

Medical Insurance Information

Policy Holder's Name: _____ Birthdate: _____
 Social Sec # _____ - _____ - _____ OR Member ID # _____
 Insurance Company: _____
 Insurance Phone # _____
 Group Number: _____

We ask for this information as a result of changes in healthcare laws and will only use this information if there are dental benefits embedded in a health insurance plan.

DENTAL / MEDICAL INFORMATION

Patient Name: _____

PROVIDER INFORMATION

Name- Previous Dentist: _____ Phone: _____ Has your child ever had an injury to the teeth, lips, tongue or chin? Yes No
 May we contact previous dentist for records/xrays? Yes No Were previous dental experiences positive? Yes No

Pediatrician/Physician: _____ Phone: _____ Address: _____
 Name of any other specialist: _____ Specialty: _____ Phone: _____
 Date of last regular check-up: _____

FLUORIDE & TOOTH BRUSHING

Is your child taking fluoride supplements presently? Y N; If Yes, what form? _____
 How much water does your child drink/day? _____ glasses / day
 Does your child drink: Bottled water Well water City water
 If you have a water filter, what type is it? Carbon Reverse Osmosis Other _____
 Does your child use a fluoride toothpaste? Y N; Does s/he swallow the toothpaste? Y N
 Brushing Frequency Inventory: AM PM Both
 What type of toothbrush does your child use? Regular Electric Cloth Other _____
 Dental flossing inventory: Once daily Occasionally Never By parent By child
 Who is responsible for tooth brushing? Parent Child Both

DIETARY FACTS / HABIT ASSESSMENT

Does your child eat between meals? Yes No
 Is your child a good eater? Yes No
 Does s/he eat a balanced diet? Yes No
 Does s/he snore? Yes No
 If not, what are the problem areas? _____
 Please list your child's favorite snacks: _____
Please check if any of the following habits exist or existed:
 Thumbsucking Pacifier
 Grinding Teeth Other Habits: _____
 At what age was bottle/nursing stopped? _____

MEDICAL NARRATIVE

1. Is your child:
 - Under the care of a doctor at the present time? No Yes, when? _____ Why? _____
 - Taking any medications at the present time? No Yes, what? _____
 - Allergic to any medications? No Yes, what? _____
 - Allergic to any foods, materials or dyes? No Yes, what? _____
2. Has your child:
 - Had general anesthesia? No Yes
 - Had any complications with general anesthesia? No Never had general anesthesia Yes, please explain _____
 - Had any surgeries? No Yes, when? _____ Why? _____
 - Ever been a patient at the Emergency room? No Yes, when? _____ Why? _____
 - Ever been hospitalized as a patient? No Yes, when? _____ Why? _____
3. Does your child have, ever had or been diagnosed with any of the following: (please check all that apply)

| | | | |
|---|--|---|---|
| <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Brain Surgery | <input type="checkbox"/> Hearing loss/aids/implants | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Anemia/Sickle cell trait | <input type="checkbox"/> Cancer-type: _____ | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Allergy /Hay fever | <input type="checkbox"/> Chemotherapy/radiation | <input type="checkbox"/> Heart problem/surgery | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Arthritis / Rheumatism | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Reactive Airway Disease |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Hepatitis A,B or C | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Artificial joint or limb: _____ | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> High/low blood pressure | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Convulsions/seizures | <input type="checkbox"/> Hormonal disturbance | <input type="checkbox"/> Scarlet fever |
| <input type="checkbox"/> Attention Deficit Disorder /ADHD | <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Sensory Integration Disorder |
| <input type="checkbox"/> Behavior/Learning Disabilities | <input type="checkbox"/> Digestive disturbances | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Shunts |
| <input type="checkbox"/> Problem concentrating | <input type="checkbox"/> Down Syndrome | <input type="checkbox"/> Liver problems | <input type="checkbox"/> _____ VA _____ VV _____ VP |
| <input type="checkbox"/> Problem learning | <input type="checkbox"/> Ear aches | <input type="checkbox"/> Malignant hyperthermia | <input type="checkbox"/> Speech problems |
| <input type="checkbox"/> Problem cooperating | <input type="checkbox"/> Emotional disturbances | <input type="checkbox"/> Measles | <input type="checkbox"/> Surgeries |
| <input type="checkbox"/> Problem understanding | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps | <input type="checkbox"/> Syndrome: _____ |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Eye problems | <input type="checkbox"/> Mouth ulcers | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Birth defects | <input type="checkbox"/> Fainting | <input type="checkbox"/> Nutritional disturbances | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bone/Joint/ Orthopedic problems | <input type="checkbox"/> Glandular disturbance | <input type="checkbox"/> Organ transplant | <input type="checkbox"/> Whooping cough |

Please discuss any of the above checked items further: _____
4. Does your child have any other condition not mentioned above? No Yes, please list _____

I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status.

SIGNED _____ RELATIONSHIP TO CHILD _____ DATE _____

PEDIATRIC DENTISTRY INFORMED CONSENT FOR ANXIETY REDUCING TECHNIQUES

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

ALL IN GOOD INTENTION

It is our intent that all professional care delivered in our dental office shall be of the best quality we can provide for each child. Our mission is to provide dental care in a manner which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life.

All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In some cases, further anxiety reducing techniques are needed when providing operative care such as fillings. There are several anxiety reducing techniques that are used by pediatric dentists to calm the child, gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. These techniques are **not** a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

Please read this form carefully & ask about anything you do not understand.

Parents are welcome to be with their child at all times. Please initial each line to identify that you understand the techniques we may use.

- _____ **1. Tell-Show-Do:** The dentist or assistant explains to the child what is to be done using age appropriate terminology, then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
- _____ **2. Positive reinforcement:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, or a prize.
- _____ **3. Mouth props/Rubber dams:** A mouth prop or "tooth pillow" as we call it is used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc) This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a "raincoat" placed on the area of work to be worked on to isolate the teeth, protect the tissues and prevent debris from being swallowed.
- _____ **4. Protective stabilization:** The dentist, assistant, and/or parent help control the child from movement by gently holding the child's hands or upper body, stabilizing the child's head for operative procedures (not routine cleanings). This is done for the child's safety and only used with additional consent.
- _____ **5. Relaxation Gas:** Nitrous oxide and oxygen (laughing gas) may be administered to relax the child and to raise his/her pain threshold. This allows the child to sit in chair longer / increases their attention span and allows for more work to be done without the child labeling something as painful. **Nitrous oxide and oxygen is not general anesthesia.** The child is not "put to sleep" and does not become unconscious, only relaxed. Additional consent is obtained.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. The listed pediatric dentistry management techniques have been explained to me.
2. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in the pediatric dental community and are merely used only if necessary to provide the best dental care.
3. I have been encouraged to ask questions about the anxiety reducing techniques described and they have been answered in a satisfactory manner.
4. I hereby acknowledge that I have read and understand this consent.
5. I acknowledge that I have not been coerced/ forced to sign this consent and that I have been given the alternative to withdraw from it.
6. I hereby authorize and direct Dr. Donaldson and/or Dr. Vuong, assisted by other dentists and/or dental auxiliaries of her/his choice, to utilize, if required, the necessary anxiety reducing techniques to assist in the provision of the required dental treatment for my child (or legal ward).
7. I understand that this consent shall remain in effect until terminated by me.

Patient Name

Person Authorized to Consent

Relationship To Patient

Date

OFFICE POLICIES

Thank you for making an appointment with our office. We appreciate the opportunity to provide dental care for your family. Because we value our relationship with you and believe the best relationships are those based on understanding and clear communication, we would like to acquaint you with our financial and office policies.

- 1) **Insurance:** We are happy to file your insurance claim for you with the understanding that you are providing us information at each visit regarding your current plan. It is important to become familiar with your insurance plan; if you have questions, please contact your insurance company or employer directly. Remember that even if you have dental insurance, you are responsible for payment of your entire account. Dental plans rarely cover all dental costs, and you are responsible for any unpaid amount. We will be happy to help you receive the maximum benefit available to you under your policy. However, please realize that the relationship is between you, the insured, and your insurance company. All unmet deductibles and copayments will be due at each visit. We prefer not to send out statements. This keeps our costs down, and as a result, your cost down.
- 2) **Estimated Fees.** After the examination and diagnosis, if treatment is needed, we will **estimate** the treatment fee. This will enable you to know what type of treatment is planned and what your **estimated** financial responsibility will be for the treatment.
- 3) **Payment in full is due at time of service.** All copayments and deductibles are due on the date services are rendered. Self-pay accounts are given a 10% discount and are required to pay at the time of service in full.
- 4) **Payment Methods:** We accept checks, cash, Visa, and MasterCard for your convenience. We are pleased to offer Care Credit to accommodate families who desire monthly payment plans. Please inquire with our front desk if interested. A \$30.00 fee is charged for all returned checks.
- 5) **All balances over 60 days are considered past due.** We will make our best attempt to communicate with you regarding past due balances. In the event of default, you will be responsible for collection agency fees or reasonable attorney fees as a result of default.
- 6) **Responsibility of account.** We realize that many families are in a state of change. Divorced, separated, single parent and blended families are common. **Our policy is that the parent who brings the child to appointments is ultimately responsible for fees incurred; regardless of named insured or custody arrangement, unless other arrangements are made with our office in advance and in writing.** We ask that these conversations are discussed prior to appointments, and arrangements are clear between parents.
- 7) **Refunds:** In the event that insurance pays higher than our estimate, your account will have a credit. You can utilize the credit in a future appointment or you can request a refund. Credits of \$10 or less are always left as a credit unless you advise us differently. Refunds are processed through our off-site book keeper, and take 4-6 weeks to process. A check will be mailed to the home address we have on file.
- 8) **Missed Appointments:** We do our best to accommodate our patients with appointments convenient for them. As such, we request **24 hours cancellation notice for appointments. Cancellations made less than 24 hours, or failed appointments will be assessed a \$25.00 charge. If the appointment is for operative treatment, the charge is \$50.00.** We are aware that unforeseen events sometimes require missing an appointment. Fees are assessed after the 2nd missed appointment. Everyone's time is valuable; please value the time with our office as we value your time.
- 9) **Late Arrival:** We reserve a certain amount of time for your appointment. If you are over 15 minutes late to your appointment, we may need to reschedule your appointment.

We hope you find this information helpful.

If you have questions regarding your account or our office policies, please contact us.

Please indicate that you have read and understand the above information by signing below.

Patient Name: _____ Parent / Guardian _____

Signature of Parent/ Legal Guardian _____ Date: _____

Sugar Bugs Pediatric Dentistry
7578 Sheridan Blvd.
Arvada, CO 80003
303-427-9779

CONSENT FOR PREAUTHORIZATION TO TREAT MINORS

For families who are ongoing patients of Sugar Bugs Pediatric Dentistry, it may be convenient to have prior authorization for dental care delivered to minors without a parent having to be present at the time of treatment.

Please review the following authorization and complete the information if you want to authorize such treatment in advance.

Authorization will remain effective until further written notice given.

AUTHORIZATION:

I (We) _____ request and authorize Sugar Bugs Pediatric Dentistry to
(Parent / legal guardian)

deliver dental care to my (our) child/children listed below:

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

I (We) give the following permission to bring our child in for treatment:

Full Name: _____ **Relationship to Patient:** _____

Full Name: _____ **Relationship to Patient:** _____

Full Name: _____ **Relationship to Patient:** _____

Full Name: _____ **Relationship to Patient:** _____

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

SUGAR BUGS PEDIATRIC DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Susan Correia
Telephone: 303-427-9779
Address: 7578 Sheridan Blvd. Arvada, CO 80003

Right of Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that the revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE OF PARENT/GUARDIAN (OR PATIENT IF 18 YEARS OF AGE OR OLDER)

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SIGNATURE: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.