# PATIENT REGISTRATION

**PATIENT**

Legal Name: _____ Preferred Name: _____
Birthdate: _____ Gender ____M ____F
Child Lives With: ___Both parents ___Mother ___Father ___Other:_____

**PARENT LEGAL GUARDIAN**

__ Mother __ Father __Stepmother __Stepfather __Grandmother __Grandfather __Other: _____

Legal Name:_____ Preferred Name:_____
Address: _____ City _____ ST____ Zip_____
Cell#_____ Home#_____ Birthdate:_____
SS#: _____- _____- _____ Driv. Lic.#:_____ State_____
Email Address: _____
Employer: _____Occupation: _____

**PARENT LEGAL GUARDIAN**

__ Mother __ Father __Stepmother __Stepfather __Grandmother __Grandfather __Other: _____

Legal Name:_____ Preferred Name:_____
Address: _____ City _____ ST____ Zip_____
Cell#_____ Home#_____ Birthdate:_____
SS#: _____- _____- _____ Driv. Lic.#:_____ State_____
Email Address: _____
Employer: _____Occupation: _____

Parents Marital Status: ___ Married ___Partnered ___Divorced ___Separated ___Widowed ___Single

**Emergency Contact** (Other than parents/legal guardians above)
Name: _____ Relationship: _____ Phone # _____

**May we thank anyone for referring you to us?**
Pediatrician: _____ Dentist: _____ Friend: _____
Family: _____ Other: _____ Website:____ Sign:____

**PRIMARY Dental Insurance Information -If insurance, ALL FIELDS REQUIRED**
Policy Holder's Name: _____ Birthdate: _____
Employer: _____ Social Sec # _____ - ____ - _____ Member ID_____
Relationship to patient: ___ Parent __ Self ___ Other: _____ Group Number:_____
Ins. Co. _____ Ins Ph# _____ _____

**SECONDARY Dental Insurance Information -If insurance, ALL FIELDS REQUIRED**
Policy Holder's Name: _____ Birthdate: _____
Employer: _____ Social Sec # _____ - ____ - _____ Member ID_____
Relationship to patient: ___ Parent __ Self ___ Other: _____ Group Number:_____
Ins. Co. _____ Ins Ph# _____ _____

**Medical Insurance Information**
Policy Holder's Name: _____ Birthdate: _____ Social Sec # _____ - ____ - _____
Member ID # _____ Ins. Co: _____ Ins. Ph # _____

**Other Patients in household**
_____ DOB _____ _____ DOB _____
_____ DOB _____ _____ DOB _____
_____ DOB _____ _____ DOB _____

# DENTAL / MEDICAL INFORMATION

**Patient Name:** _____

## PROVIDER INFORMATION

Name- Previous Dentist: _____Phone:_____
May we contact previous dentist for records/xrays? ____Yes ___ No

Has your child ever had an injury to the teeth, lips, tongue or chin? ___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)

| | | | |
|---|---|---|---|
| __HIV+/AIDS | __Brain Surgery | __Hearing loss/aids/implants | __Pneumonia |
| __Anemia/Sickle cell trait | __Cancer-type: _____ | __Heart murmur | __Polio |
| __Allergy /Hay fever | __Chemotherapy/radiation | __Heart problem/surgery | __Pregnancy |
| __Arthritis / Rheumatism | __Cerebral Palsy | __Hemophilia | __Reactive Airway Disease |
| __Artificial heart valve | __Cleft Lip/Palate | __Hepatitis A,B or C | __Respiratory Problems |
| __Artificial joint or limb:_____ | __Chicken Pox | __High/low blood pressure | __Rheumatic fever |
| __Asthma | __Convulsions/seizures | __Hormonal disturbance | __Scarlet fever |
| __Attention Deficit Disorder /ADHD | __Developmentally Delayed | __Hydrocephalus | __Scoliosis |
| __Autism | __Diabetes | __Kidney problems | __Sensory Integration Disorder |
| __Behavior/Learning Disabilities | __Digestive disturbances | __Leukemia | __Shunts |
| __Problem concentrating | __Down Syndrome | __Liver problems | __VA __ VV __ VP |
| __Problem learning | __Ear aches | __Malignant hyperthermia | __Speech problems |
| __Problem cooperating | __Emotional disturbances | __Measles | __Surgeries |
| __Problem understanding | __Epilepsy | __Mumps | __Syndrome: _____ |
| __Bleeding disorder | __Eye problems | __Mouth ulcers | __Tetanus |
| __Birth defects | __Fainting | __Nutritional disturbances | __Tuberculosis |
| __Bone/Joint/ Orthopedic problems | __Glandular disturbance | __Organ transplant | __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 based on understanding and clear communication, we would like to acquaint you with our financial and office policies.

**Payment is due in full at time of service. Your estimated amount, including:** All copayments and deductibles are due on the date services are rendered. **If your child is being seen without a parent at any visit, payment is due by phone while your child is in the office.**

- A Courtesy discount of 20% is given for those without insurance**. PAYMENT IN FULL is REQUIRED at the time of service.**

**Insurance:** We are happy to file your insurance with the understanding that you provide information **at each visit regarding your plan**.

- You are ultimately responsible for any payment due for each visit, even if we are filing insurance on our behalf. It is your responsibility to learn about your insurance plan; if you have questions, please contact your insurance company or employer directly.
- Dental plans rarely cover all dental costs, and you are responsible for any unpaid amount. We are happy to help you receive the maximum benefit available under your policy. However, please realize that the relationship is between the insured and your insurance company. We prefer not to send out statements. This keeps our costs down, and as a result, your costs down.
- For those with insurance, If your insurance pays you directly, you are required to pay the full balance on your account within 10 days.
- IF your insurance has paid you directly, future visits will be DUE IN FULL AS SEEN at each visit and we'll file for you to receive any amount your insurance chooses to pay to you.

**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. You are responsible for any non-covered amounts at the time treatment is provided. In addition, you will also be responsible for any additional amounts not covered by insurance within 30 days.

**Payment Methods:** For your convenience, we accept cash, checks, and all major Credit Cards. We also offer Care Credit to accommodate families who desire monthly payment plans. ***We do NOT offer in-house financing or payment plans***. Please inquire with our front desk team if interested in Care Credit. A $30.00 fee is charged for all returned checks.

**Responsibility of account.** Blended, separated, divorced, and single parent families are common. The insured parent is NOT automatically considered financially responsible. Our policy is that the parent bringing the child to the appointment is responsible for fees incurred**, regardless of named insured or custody arrangement, unless** other arrangements are made with our office, IN ADVANCE and IN WRITING, signed the parent who will be paying. **The amount due and payment required should be communicated to anyone bringing your child to appointments**. We bill only the PRIMARY contact on the account. It is the responsibility of the parent who received bills to share information with any other parent(s). We stay clear of payment concerns/disputes between parents.

**All balances over 30 days are considered past due.** We will make our best attempt to communicate with you regarding balances that remain after insurance pays. Billing may be sent by text, email and mail. **If a balance remains after 60 days, a $30 late fee is assessed & the account may be turned over to a 3rd party billing company.** In the event of default, you will be responsible for collection agency fees and/or attorney fees because of default.

**Missed Appointments:** We do our best to accommodate our patients with appointments convenient for them. We require a minimum **24 business hour cancellation notice for all appointments. Cancellations less than 24 business hours, or failed appointments will be assessed a $25.00 charge. If the canceled or failed 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.

**Late Arrival:** We reserve a certain amount of time for your appointment. If you are 15 minutes late (or more), 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 speak with our team.

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

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**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 _____ request and authorize Sugar Bugs Pediatric Dentistry to provide
Parent / legal guardian)

dental care to my child:

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

I give the following person(s) 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: CONSENT FOR:**

**PATIENT NAME:**_____

**SECTION B: TO THE GUARDIAN/PATIENT– PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your/your child's 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: Tandi Donaldson, DDS, MS and/or Julie Vuong Taylor, DDS
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.**