**Children's Dental Center of Rock Springs**

**Weston Jones, D.M.D.**

**Board Certified Pediatric Dentist**

Date: _____

## Patient Information:

Name: _____ Nickname: _____ DOB: _____

*Last Name* *First Name* *Middle Initial*

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Mobile: _____

Appointment reminder text: ◯ YES ◯ NO Number we can text: _____

Social Security Number: _____ Sex: ◯ Male ◯ Female

Grade: _____ School/Daycare: _____

Names/Ages of other Children in Family: _____

HOW DID YOU HEAR ABOUT US?

◯ Radio ◯ Television ◯ Insurance ◯ Internet

◯ Walk-In ◯ Personal Reference ◯ Local Event ◯ Other _____

## Responsible Party:

Name: _____ DOB: _____

*Last Name* *First Name* *Middle Initial*

Relationship to Patient: _____

Social Security Number: _____ Contact Phone Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Email Address: _____ Employer: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

Emergency Contact: _____ Phone: _____ Relationship to Patient: _____

# Medical History Questionnaire

*Your child's overall health as well as any medications which your child takes could have an important role with the dental they receive. Please answer the following questions accurately and completely.*

Has your child been to the dentist before? ◯ YES ◯ NO

How would you rate your child's experience at the previous dentist? ◯ GOOD ◯ BAD

Does your child take Fluoride Supplements? ◯ YES ◯ NO

How often does your child brush their teeth? _____ Floss? _____

**Please mark for the following behaviors if applicable regarding your child:**

◯ Sucks fingers/thumbs
◯ Sucks/bites lips
◯ Bites/chews nails
◯ Chews on hard objects (pencils, ETC)
◯ Grinds teeth
◯ Clenches Jaw

**Please mark below if applicable:**

◯ Heart Disease/murmur
◯ Bleeding/Transfusions
◯ Asthma Blood
◯ Dyscrasias
◯ Liver/GI diseases
◯ Anemia
◯ Diabetes
◯ HIV/Aids
◯ Kidney Disease
◯ Rheumatic Fever
◯ Hepatitis
◯ Mental delays
◯ Speech/hearing problems
◯ Seizures
◯ Cleft lip/Palate
◯ Physical delays
◯ Cerebral Palsy
◯ Congenital
◯ Birth defects
◯ Cancer/tumors
◯ Personality/social
◯ Recurrent headaches
◯ Frequent infections _____
◯ Other _____

Please explain any items checked above: _____

Please list any medications your child takes: _____

_____

Please list all previous hospitalization/surgeries/illnesses:_____

Child's Primary Doctor: _____ Office Number: _____

Is your child allergic to latex or any medications? ◯ YES ◯ NO

If so, please list: _____

What Pharmacy does your family use? _____

Signature of Responsible Party:_____ Date: _____

# Dental Insurance

## Primary Dental Insurance

Subscriber Name: _____

*Last Name* *First Name* *Middle Initial*

Relationship to patient: _____ DOB: _____

Social Security Number: _____

Insurance Company: _____

Subscriber ID#: _____ Group #: _____

Insurance Company Contact Phone Number: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ Employer: _____

## Secondary Dental Insurance

Subscriber Name: _____

*Last Name* *First Name* *Middle Initial*

Relationship to patient: _____ DOB: _____

Social Security Number: _____

Insurance Company: _____

Subscriber ID#: _____ Group #: _____

Insurance Company Contact Phone Number: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

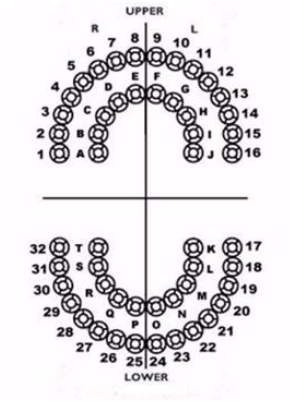
Email Address: _____ Employer: _____

I hereby authorize payment directly to Dr. Jones for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance, and for all services rendered on my behalf of my dependents. I authorize the above doctor and/or any provider or supplier of services in this office to release information required to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

I certify that the information that I have provided above is, to the best of my knowledge, correct and accurate.

Guardian Signature: _____ Date: _____

# Pediatric Treatment Consent




I understand that my child will have dental procedures performed today. Please acknowledge that your child's well-being and comfort is important to us. The treatment may include the use of oral anesthesia, nitrous oxide and sedative or radiographs that may be necessary to provide the best possible care for your child. In general terms, the procedure(s) may include, but are not limited to the following:

- Preventative &Diagnostic Treatment: Dental cleaning, Fluoride application, Sealant application to dental fissures, and/or Radiographs as necessary
- Restorative Treatment: Composite Filling(s), Stainless Steel Crown(s), and/or Direct or indirect Pulpotomy(s)
- Removal of Teeth: Simple Extraction(s), Surgical Extraction(s), Root Tip Removal, Removal of Wisdom Teeth, and/or Impacted teeth
- Orthodontic Treatment: _____
- Changes in Treatment Plan: I understand that during treatment, it may be necessary to change or add procedures because of conditions discovered but were not evident during examination. I authorized the doctor to use professional judgment to provide appropriate care
- Drugs and Medication: I understand that antibiotics, analgesic, anesthetics and other medications can cause allergic reactions, resulting in redness and swelling of tissues, itching pain, nausea and vomiting or more severe allergic reactions. I have informed the doctor of any know allergies and medications that the patient is currently taking
- Nitrous Oxide: I understand nitrous oxide (laughing gas) provides relaxation to make it more comfortable for my child to receive the necessary dental care with less anxiety. He/she will be awake, fully conscious, aware of his/her surroundings and able to respond rationally. I have informed the doctor of my child's complete medical history, including any recent surgeries, illnesses and changes in health history since his/her last visit
- Local Anesthetic: I understand there are risks of local anesthesia that may affect my child's body such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, of various types of allergic reactions. It may also cause injury to nerves that can result in pain, numbness and/or tingling that may persists for several weeks, months or rarely permanent. I have informed the doctor of my child's complete medical history, including any recent surgeries, illnesses and changes in health history since his/her last visit
- Removal of Teeth: Alternatives to tooth removal have been explained to me. I understand that removing teeth does not always remove existing infection and that further treatment may be necessary. I understand that the risks of removing teeth include, but are not limited to: pain, swelling, bleeding, infection, dry socket, fracture of bone or jaw and loss of feeling in my lip or other facial areas, cheek, tongue, gums and teeth. Such as numbness may be temporary or permanent. Also, there is the possibility of a small root pieces being left in the jaw where the risks of removing it outweigh the benefits. I understand that further care by a specialist or even hospitalization may be needed if complications arise during the treatment, and that cost incurred are my responsibility

Financial Arrangements: I acknowledge that I am responsible for knowing what my insurance will cover. I understand the office has made every attempt to estimate what my treatment will cost and what insurance will pay including contacting them to confirm coverage and that I am responsible for any portion that is not covered by insurance

Insurance Payment Authorization:

A. By signing below, I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law or the treating dentist or dental practice has contractual agreements with my plan prohibiting all or portion of such charges to the extent permitted by law. I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.
B. I also hereby authorize the direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or the dental entity.

Patient's Name: _____ Date: _____

Parent/Guardian Signature: _____ Provider Signature: _____

# Financial Policy

Please read carefully and sign to acknowledge understanding and agreement. Thank you for choosing us as your dental care provider. We are committed to providing you with best dental care available.

*Available payment options:* **Cash, Check, Visa, MasterCard, American Express, and CareCredit.** We offer a 10% courtesy adjustment to patients who pay for their treatment, at the time of scheduling your next appointment. We offer **CareCredit** payment plan options, please ask us for detailed information.

*Regarding Insurance:*

- For covered services, we ask that all co-pays and deductibles be paid on the day of treatment. Since your insurance company may not cover all cost, we require that you pay for any remaining balance not paid by your insurance on the day of treatment.
- For services that are not covered by your insurance, we ask that you pay the entire fee the day of your treatment.
- We will attempt to answer any questions we can about your insurance and, when possible, we will assist in resolving complications with your insurance company. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer, and your insurance carrier. In the event that your insurance company has not paid (on your behalf), you will be responsible to pay on your account.

*Patients without Insurance:*

- For those patients without insurance coverage, you will be responsible for payments on the day of treatment. If you are not able to pay in full, or if your treatment requires several visits, you will be given an estimate and will be able to discuss payment arrangements with a member of our business office staff.

*Cancellation/No Show Policy:*

- Since our profession is based in an appointment schedule, our policy requires notice to cancel your appointment in the case of an emergency.
- **We reserve the right to charge a $50 fee for those not giving notice.**

*Collections:*

- A grace period of 30 days is extended before an interest rate of 24% MPR begins to accrue. This means a monthly fee of 24% of your account balance will be added to your account balance will be added to your account which will be your responsibility.
- A $30 charge will be added to your account for nay returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on this account. If you are delinquent and your account goes over 90 days, you will be turned over to a collection agency. If that happens your balance will increase by 35% to cover attorney's fees, interest and late fees.

I hereby authorize payments to Dr. Jones.

I understand and have read the financial policy of this office.

Signature: _____ Date: _____

# No Show, Missed Appointment Policy

Your appointment is very important to us. We reserve time specifically for you. We have more patients that need dental care than we have room in our daily schedule. When a patient does not show up to their appointment or cancels too close to their scheduled time, we are unable to fill the time slot with a patient on our waiting list who desperately needs dental care. Therefore, we respectfully request at least a 24-hour notice for cancellations or rescheduling of appointments. This will ensure efficiency within our practice and provide high quality care to all patients.

We understand that emergencies happen and we'll work with our patients as best we can with unforeseen events. These absences will be considered on a case-to-case basis.

**There is a charge of $50 for not showing up for your appointment**.

If you have failed to cancel/reschedule 24 hours before your appointment time, $50 will be added to your account. Additionally, that $50 will have to be paid off before we can reserve you a space in our schedule.

As a courtesy to you, we will send out reminder texts and calls about your appointment. You can confirm or request rescheduling within that service. If we have not received a text or call back from you, we will assume you are not coming and put the no show charge on your account.

By signing this, you understand and respect our policy. If you do not show up to your appointment or fail to cancel before the 24-hour window, you will be charged $50 and will have to pay that $50 before reserving your next appointment.

Sign_____ Date_____

We appreciate our patients and thank you for understanding as we strive to provide the utmost care and consideration to your children's dental needs.

# Picture Permission

- Yes, I give Children's Dental Center of Rock Springs permission to use my child _____'s picture for in-house bulletin boards, picture frames, and social media.*
- Yes, I give Children's Dental Center of Rock Springs permission to **ONLY** use my child _____'s picture of in-house bulletin boards and picture frames.
- No, I don't give Children's Dental Center of Rock Springs permission to use my child _____'s picture.

By signing this, I understand that if I agree to accept, my child's picture will be hung up or put in a picture frame in the dental office.

Print Name: _____

Signature: _____

**We will also get verbal permission if we want to use your child's picture on our Facebook page.*

## Acknowledgement of Notice Privacy Practices

*****You may refuse to sign this acknowledgement*****

I, _____ , have received a copy of this office's notice of Privacy Practices.

_____

PLEASE PRINT NAME

_____

SIGNATURE

_____

DATE

## FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our privacy practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify) _____

  _____

  _____