Children's Dental Center of Rock Springs
DR. WESTON JONES

Date:_____/_____/_____

Patient Information:

Name:_____ Nickname:_____
Last Name *First Name* *Middle Initial*

Address:_____ City_____ State_____ Zip_____

Home Phone_____ Cell Phone_____ DOB:_____/_____/_____

Appointment reminder text: Yes ◯ No ◯ Number we can text _____

Social Security #_____-_____-_____ Sex: Male ◯ Female ◯

Grade_____ School/Daycare_____

Name /Ages of other Children in Family:_____

HOW DID YOU HEAR ABOUT US?

◯ Radio ◯ Television ◯ Insurance ◯ Internet
◯ Walk-In ◯ Personal Reference ◯ Local Event ◯ Other_____

Parent Name_____ Phone:_____
Parent Name_____ Phone:_____
Emergency Contact: _____ Phone: _____ Relationship to patient:_____

Primary Dental Insurance:

Subscriber Name:_____
Last Name First Name Middle Initial

Relationship to Patient_____ DOB:_____/_____/_____

Social Security #_____-_____-_____ Contact Phone Number:_____

Address:_____ City:_____ State:_____ Zipcode_____

Email Address:_____ Employer:_____

Insurance Company:_____ Phone Number:_____

Subscriber ID#:_____ Group #:_____

Guardian Signature:_____ Date:_____/_____/_____

Children's Dental Center of Rock Springs
DR. WESTON JONES

Your child's overall health as well as any medications which your child takes could have an important role with the dental care he/she receives. 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?_____

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

Please mark for the following questions if applicable regarding your child:

◯ Sucks fingers/thumbs
◯ Chews on hard objects (pencils, ETC)
◯ Sucks/bites lips
◯ Grinds teeth
◯ Bites/chews nails
◯ 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
◯ Personality/social
◯ Other_____
◯ Cancer/tumors
◯ Recurrent headaches
◯ Frequent infections_____

Please explains any items checked above:_____

Please list any medications your child takes:_____

_____

Please list all previous hospitalizations/surgeries/illnesses:_____

Child's primary doctor:_____ Phone Number:_____

Is your child allergic to latex or any medications? YES ◯ NO ◯
If so please list:_____
What Pharmacy does your family use?_____

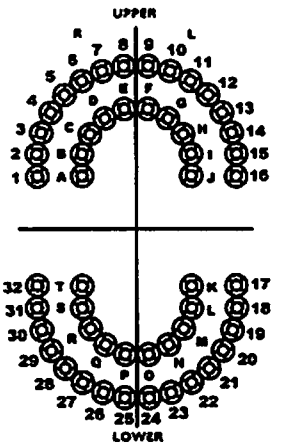
Assignment and Release

I hereby authorize payment directly to Dr._____ 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of responsible party_____ 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

Children's Dental Center of Rock Springs
1208 Hill top Drive Suite 209
Rock Springs, WY 82901
Phone: 307 362 3395
childrensdentalcenterofrs@gmail.com

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 the best dental care available.

Available Payment Options:

You can choose from ~ **Cash, Check, Visa, Mastercard, American Express, 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 costs, we require that you pay 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 your account.

Patients Without Insurance.

- **For those patients without insurance coverage, you will be responsible for payment 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 us extended before an interest rate of 24% MPR begins to accure. This means a monthly fee of 24% of your account balance will be added to your account which will be your responsibility.
- A $30 charge will be added to your account for any returned checks. You are responsible to pay all costs of collecting, or attempting to collect any debt owed on this account. If you are delinqent 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 all attorneys fees, interest and late fees.

I hereby authorize payment to Dr. Jones

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

_____ _____

Signature Date

Children's Dental Center of Rock Springs
1208 Hilltop Dr. STE 209
Rock Springs, Wy 82901
Phone:307-362-3395
Fax: 307-362-6441
childrensdentalcenterofrs@gmail.com

No show, Missed Appointment Policy

Your appointment is very important to us. We have more patients who need dental care than we have room in our daily schedule. To ensure efficiency within our practice and give high quality care, we respectfully request that if you **must** cancel or reschedule your appointment, you do so within **24 hours with the receptionist**. When our office books your appointment, we are setting aside a dedicated a time just for your treatment. This courtesy makes it possible to give your reserved time slot to another patient who has been waiting.

For your convenience, you can confirm appointments via text, phone call, or email.

If we have not received confirmation from you by 3:00pm the day before your scheduled appointment, we will cancel your appointment and your account will be charged. If you acquire a "no show" fee, that fee will have to be paid in full before we can schedule you another appointment.

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

We understand that somethings are out of our control and all emergency absences will be considered on an individual basis.

By signing this, you understand that no show appointments and appointment cancelled after the 24-hour window will be charged.

Sign_____ Date _____

Thank you for understanding as we strive to give the utmost care and consideration to your dental needs.

Children's Dental Center of Rock Springs

1208 Hill top Drive, Suite 209

Rock Springs, WY 82901

Phone: 307 362 3395

Picture Permission Slip

- 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 do not 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_____

Signature_____

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

Children's Dental Center of Rock Springs
Dr. Weston Jones, D.M.D.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change the Notice and make the new Notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of the notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment: We may use and disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities reviewing the competence or qualifications of healthcare professionals, evaluation practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.
Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operation, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by our authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the notice.
To Your Family and Friends: We must disclose your health information to you, as describe in the Patient Rights section of the Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.
Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.
Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format your request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notices. If you request copies, we will charge you $120.00 for staff time to alternative format: we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of the Notice for a full explanation of our fee structure.)
Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other that treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 1-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **(You must make your request in writing).** Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.
Amendment: You have the right to request that we ament your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Electronic Notice: If you receive this Notice on our website or by electronic mail (email), you are entitled to receive this Notice in written form.

Children's Dental Center of Rock Springs
1208 Hilltop Dr. STE 209
Rock Springs, WY. 82901
307-362-3395

Dr. Weston Jones D.M.D.

Acknowledgement of Notice of 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 Notice of Privacy Practices, but Acknowledgment could not be obtained because:

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

_____

_____

_____