

PATIENT REGISTRATION FORM

This form must be properly filled out to ensure proper payment

Today's Date _____

Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

Patient Name: _____ Date of Birth: _____ Gender M F

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Social Security Number: _____ Medicaid Number: _____

Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

Patient Name: _____ Date of Birth: _____ Gender M F

Social Security Number: _____ Medicaid Number: _____

PARENT / LEGAL GUARDIAN INFORMATION

Mother's Name: _____

Date of Birth: _____ Social Security Number: _____

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

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Father's Name: _____ Social Security Number: _____

Date of Birth: _____

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

Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Nearest Relative or Close Friend and Phone Number _____

E-mail: _____ Referred By: _____

INSURANCE INFORMATION

Primary Dental Insurance: _____

Group or Plan Number: _____ Insurance ID Number: _____

Insurance Company Address: _____ Insurance Company Phone # _____

Policy Holder's Name (Person that holds the insurance plan): _____ Date of Birth _____

Policy Holder's Social Security Number: _____ Relationship to Patient: _____

Employer: _____

Secondary Dental Insurance: _____

Group or Plan Number: _____ Insurance ID Number _____

Insurance Company Address: _____ Insurance Company Phone # _____

Policy Holder's Name (Person that holds the insurance plan): _____ Date of Birth _____

Policy Holder's Social Security Number: _____ Relationship to Patient: _____

Employer: _____

TO OUR PATIENTS AND FAMILIES

Thank you for choosing Firestone Pediatric Dentistry & Orthodontics (FPDO) for your child's dental care. We consider families to be an essential participant in your child's care and wish to support and respect your needs while your child is under our care. We want you to understand your rights and responsibilities as families and patients at FPDO. Your signature on this form provides consent for treatment and payment, and acknowledges receipt of other general information.

If you have questions, please ask your provider.

Consent for Treatment

I hereby authorize and request the performance of dental services for my minor child. I understand that at the first appointment (examination, necessary x-rays, cleaning, topical fluoride) the doctor will explain my child's treatment needs and the various behavior management approaches. At this appointment the doctor's staff will review any associated fees. I also realize that any restorative treatment will be accomplished at a later date.

Parents in the Back

You may choose whether or not you accompany your child to the treatment room for his/her appointment. Although we are sensitive to the fact that you may have more than one child and that more than one family member may want to participate, we ask that only one adult come to the back. Our goal is to not only provide the highest quality of care but also to effectively communicate with you and your child to provide as much dental education as possible. This is very difficult if both you and your child are distracted by other siblings or when a child is trying to get the attention of both of their parents at the same time.

Missed/Broken Appointment Policy

Due to the limited space in our schedule and the need to provide timely service to all of our patients it is very important that you keep your scheduled appointments. It is understandable that occasionally you may need to reschedule due to an emergency or illness. We ask that you give us the courtesy of a 24 hour notice so that we will have the opportunity to use your appointed time to provide treatment for others in need. If you cancel your appointment without 24 hour notice or if you "No-Show" for your appointment, then you will be required to a pay a **\$50.00 Non-Refundable Fee**.

Assignment of Benefits (AoB) and Release of Information (RoI)

- I consent to and authorize that payment of benefits for healthcare related services be made to FPDO. This consent specifically authorizes FPDO to release Protected Health Information (PHI) to insurers, governmental agencies and their agents for billing purposes and determination of benefits.
- I assign any benefits payable for provider services to the provider or organization providing the services.
- **I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of FPDO and of providers rendering services not otherwise paid by my health insurance or other payer. All charges due are payable upon receipt of the bill. If payment is not made within 60 days after receipt of bill, a delinquent charge or interest of 18.00% (1.5% monthly rate will be added. I agree to pay all costs of collection including attorney fees, collection fees and court costs.**
- The terms of this AoB and RoI will be until final payments are made for all services.
- If and when there are any changes to my insurance plans, I will notify FPDO staff and sign a new agreement.

Insurance

AT THIS OFFICE WE FOLLOW THE GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY IN REGARD TO FREQUENCY OF X-RAYS, CLEANINGS, FLUORIDE TREATMENTS, AND RESTORATIVE CARE. AS SPECIALISTS WE CONSIDER THESE GUIDELINES TO BE THE STANDARD OF CARE (BEST TREATMENT FOR YOUR CHILD). THESE GUIDELINES ARE NOT DICTATED BY DENTAL INSURANCE AND IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHETHER YOUR PARTICULAR INSURANCE PLAN WILL REIMBURSE YOU FOR THESE SERVICES. PLEASE CALL YOUR INSURANCE COMPANY WITH QUESTIONS REGARDING FREQUENCIES.

Print Patient's Name

Print Patient's Name

Print Patient's Name

Print Patient's Name

Print Patient's Name

Print Patient's Name

Parent/Guardian Signature

Parent/Guardian Print your name

Relationship to Patient

Date

NOTICE OF PRIVACY PRACTICES

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

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). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

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. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- We may have violated your privacy rights,
- We made a decision about access to your health information incorrectly,
- Our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- We should communicate with you by alternative means or at alternative locations,

You may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Firestone Pediatric Dentistry & Orthodontics
8310 Colorado Blvd. Suite 200
Firestone, CO 80504

Patient: I have read and understand the above Patient Rights to Privacy Information.

Patient Signature (or Parent/Guardian if child)

Date

CONSENT FOR DENTAL TREATMENT

I understand that DENTAL TREATMENT is associated with inherent risks, including, but not limited to, the following:

1. **Injury to the nerves as a result of local anesthesia:** This would include injuries causing numbness of the lips, the tongue, or other tissues of the mouth or face. This numbness is usually of a temporary nature, but permanent numbness is a possibility. If numbness persists more than 24 hours postoperatively, please call our office.
2. **Soreness of the gums:** Temporary soreness may result from the placement of a rubber dam, or any restoration that extends below the gumline (e.g. stainless steel crowns). This soreness usually goes away within 48 hours.
3. **Sensitivity of teeth:** Placement of any dental restoration can result in a tooth that is sensitive to hot and/or cold. If these symptoms persist for more than a few weeks, it may be an indication that further treatment is necessary.
4. **Breakage, dislodgement, or bond failure:** Due to the fact that teeth are subjected to extreme forces from chewing, grinding, and possible trauma, it is possible that bonded restorations (white fillings) or even amalgam restorations (silver fillings) can be fractured or dislodged, resulting in leakage, recurrent decay, or infection. The dentist has no control over the forces to which the tooth/restoration is subjected.
5. **Aesthetics:** Although dental materials are constantly improving, it is possible that bonded restorations may wear down, lose their luster, or discolor. The dentist has no control over these factors.
6. **For dental extractions:**
 - o Bleeding, bruising, or swelling: bleeding may persist for several hours. If profuse, please call our office. Some swelling is normal, but if severe, please call our office. Bruising may persist for some time, but generally heals uneventfully.
 - o Injury to adjacent teeth or restorations: This is a possibility no matter how carefully the surgery is performed.
 - o Infection: Due to the non-sterile nature of the mouth, or perhaps due to an existing infection, post-operative infection is a possibility. Some infections can be very serious. If severe swelling occurs, particularly if associated with fever or malaise, please call our office as soon as possible.
7. **For endodontically treated teeth:**
 - o Pulpotomies: In a small percentage of cases, the patient's body "rejects" the nerve treatment, resulting in a failed pulpotomy and the need for extraction. The dentist has no control over the body's biological response to treatment.
 - o Pulpectomies: For teeth requiring a pulpectomy, the long term prognosis is guarded. A significant percentage of pulpectomized primary teeth ("baby teeth") will ultimately need to be extracted. This treatment is generally used when short term retention of a primary tooth is important to long term dental health.
8. **IT IS MY RESPONSIBILITY TO SEEK ATTENTION SHOULD ANY COMPLICATIONS OCCUR POST-OPERATIVELY AND I SHALL DILIGENTLY FOLLOW ANY INSTRUCTIONS GIVEN TO ME BY THE DENTIST.**
9. **For those children receiving nitrous oxide analgesia:** Potential side effects include dizziness, nausea, and vomiting. Nitrous oxide should be avoided if your child has just eaten a large meal.

INFORMED CONSENT: I have been given the opportunity to ask questions regarding the proposed treatment and have received answers to my satisfaction. I have been given alternatives to this treatment, including the option of rendering *no* treatment. I understand and assume any and all risks associated with the procedures, and I understand that no guarantees have been made regarding the outcome of the treatment. By signing this form, I am freely giving my consent to allow and authorize Dr Brady and Dr. Lane to render treatment, including any anesthetics or medications.

Print Patient's Name

Print Patient's Name

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Print Patient's Name

Print Patient's Name

Print Patient's Name

Parent/Guardian's Name

Parent/Guardian's Signature

Witness

Date



Firestone Pediatric Dentistry & Orthodontics
8310 Colorado Blvd. Suite 200
Firestone, Co 80504

In case someone other than you (the parent/ legal guardian) accompanies your child to future dental appointments, may this person (if over 21 years) give consent by proxy to possible treatment plan changes? For example: the patient's sister or aunt brings the child to the appointment and a tooth that was planned to receive a silver filling needs a crown. May this person decide for you this change?

YES NO

If NO, what should we do?

Reschedule. A parent will come with the patient to the next appointment.

Call (____)_____ to discuss the change with a parent.

If nobody can be reached we will reschedule.

I _____ give my permission to

(parents name)

_____ to bring my

(authorized person)

child/children _____

_____ to his/her dental

(patients name)

appointments at Firestone Pediatric Dentistry & Orthodontics. In my absence

_____ is allowed to make dental

(authorized person)

and medical procedure decisions for my child, until further notice.

Signature _____

Date _____