PATIENT HEALTH INFORMATION

The following information is requested to enable us to give the most consideration to your time and feelings.
It is our sincere desire to give personal attention to each of our patients and parents.

Patient's Full Name: _____ Prefers to be called: _____

Date of Birth: _____ Age: _____ Weight: _____ M € F € Hobbies: _____

Pediatrician's Name: _____ Phone: _____

Does your child have any health problems?..…. Yes € No €
Does your child take any medicine(s) regularly? ……. Yes € No €
If yes, please list: _____
Has your child experienced any unfavorable/allergic reactions to any medicine(s)? ……. Yes € No €
If yes, please list: _____
Does your child bleed excessively when cut?…… Yes € No €
Has your child ever been hospitalized or had any surgical procedures? …….. Yes € No €
Has your child experienced any unfavorable reaction from any previous dental care? ……... Yes € No €
Does your child have a toothache now? …… Yes € No €
Has your child recently had a toothache? ……... Yes € No €
Does your child suck his/her thumb or finger(s)? …… Yes € No €
Does your child bite his/her nails? ……Yes € No €
Does your child have a pacifier, nursing bottle or sipper cup habit? …… Yes € No €

If you answered **YES** to any of the questions above, have any dental or medical problems of special concern, or want to provide any other information which you think might be important in the care of your child, please explain here: _____

_____

_____

Has your child had any history of the following or currently being treated for:

€ ADD/ADHD	€ Cardiac Issues/Heart Murmur	€ Epilepsy/Seizures	€ Lung Disease
€ Allergies	€ Cleft lip or palate	€ Handicaps/Disabilities	€ Rheumatic/Scarlet Fever
€ Anemia	€ Diabetes	€ Hearing Impairment	€ Speech Problems
€ Asthma	€ Dyslexia	€ HIV/AIDS	€ Tuberculosis
€ Bleeding Disorder	€ Emotional Issues	€ Kidney/Liver Issues	

Has your child been tested for or diagnosed with any neurological disorders? Yes € No €
€ Autism € Asperger's Syndrome € Sensory Integration Disorder
Other: (Please list) _____

Is this your child's first visit to the dentist? Yes € No €

If no, date of: last exam _____ dental x-rays _____ fluoride treatment _____

Consent for Treatment of a Minor

The undersigned hereby authorizes Carpenter Pediatric Dentistry to perform the examination and, after explanation, provide necessary dental services using methods deemed appropriate for the care of the above-named child. This consent shall remain in full force and effect until cancelled by either party. I understand that I am responsible for the full cost of necessary dental treatment for the above named child regardless of insurance coverage. I understand that I am responsible for notifying this office of any accidents, major illnesses, or changes in medical history of the above named child.

Signed _____ Date_____

Relationship to Child _____ Do you have legal custody of this child? Yes € No €

If no, who is accompanying this child today?_____ Relationship to child _____

Our office strongly recommends that the legal guardian accompany their child to each appointment. If you, the legal guardian, will not be present, we will need written consent stating that in your absence, the person bringing your child can make medical/dental decisions on your behalf.

PATIENT ACQUAINTANCE INFORMATION

Date:_____

Patient's Full Legal Name:_____

Patient's SSN: _____ Date of Birth: _____ Male € Female €

Address:_____ Home Phone: _____

City:_____ State: _____ Zip: _____

Siblings:

_____ DOB: _____ Age _____

_____ DOB: _____ Age _____

_____ DOB: _____ Age _____

_____ DOB: _____ Age _____

Whom may we thank for referring you? _____

PARENT ACQUAINTANCE INFORMATION

Parents Marital Status: €Single €Married €Widowed €Remarried €Divorced €Separated

Father's Information: €Father €Stepfather €Legal Guardian €Other: _____

First Name: _____ Last: _____ MI: _____

SSN: _____ DOB: _____ Employer: _____

Cell #: _____ Work #: _____ Email: _____

Address (if different from Patient)_____

City:_____ State:_____ Zip:_____

Mother's Information: €Mother €Stepmother €Legal Guardian €Other: _____

First Name: _____ Last: _____ MI: _____

SSN: _____ DOB: _____ Employer: _____

Cell #: _____ Work #: _____ Email: _____

Address (if different from patient)_____

City:_____ State:_____ Zip:_____

Person responsible for the account (Colorado law states custodial parent is responsible for account):

_____

Is the patient covered by insurance? Yes € No €

Emergency Contact Person: _____ Relation:_____

Address:_____ Home Phone: _____

City:_____ State: _____ Zip: _____

FAMILY INSURANCE INFORMATION

Patient's name _____
Patient's name _____
Patient's name _____
Patient's name _____

The dental insurance that covers your child is your financial responsibility. Regardless of what we might estimate as a dental benefit in dollars, we want to make it clear that you are responsible for the total cost of your child's dental treatment. As a courtesy to you, we will file your child's insurance claims and ask that you pay the estimated portion based on standard insurance coverage at the time of service. You will be billed for any remaining balance after insurance has paid.

PRIMARY DENTAL INSURANCE: In order to file your insurance correctly, **all information must be provided.**

Employee's Full Name: _____ Employee's Date of Birth: _____

Relationship to Patient: _____ Work Phone Number:_____

Social Security #: _____ Employee I.D. #:_____

Insurance Company Name:_____

Claims Mailing Address: _____ City: _____

State: _____ Zip:_____ Insurance Company Phone #:_____

Group Number:_____ Employer Name:_____

Employer City/State:_____

Address of Employee if different than patient: _____

_____

SECONDARY DENTAL INSURANCE:

Employee's Full Name: _____ Employee's Date of Birth: _____

Relationship to Patient: _____ Work Phone Number:_____

Social Security #: _____ Employee I.D. #:_____

Insurance Company Name:_____

Claims Mailing Address: _____ City: _____

State: _____ Zip:_____ Insurance Company Phone #:_____

Group Number:_____ Employer Name:_____

Employer City/State:_____

Address of Employee if different than patient: _____

_____

ASSIGNMENT OF INSURANCE BENEFITS

In consideration of services rendered, I hereby transfer and assign to:

- All rights, title, payment, and interest in any payment form due me for services as provided in the policy or policies of insurance held by me.
- I agree to pay any and all charges of Carpenter Pediatric Dentistry which exceed the amount paid by the policies held by me or any other policy that provides coverage for my child(ren).
- I agree and authorize Carpenter Pediatric Dentistry to release any information requested by the insurance company(s) or its representatives.
- The undersigned accepts full financial responsibility for the account.

Policy Holder and/or Legal Guardian Signature: _____ Date:_____

FAMILY FINANCIAL POLICY

Patient's name _____
Patient's name _____
Patient's name _____
Patient's name _____

We are pleased to welcome your family to our practice. Our desire is to provide your child(ren) with the highest quality dental care in a fun, friendly, and caring atmosphere. It is our policy to make clear financial arrangements with you before any treatment begins. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards (VISA, MasterCard, and Discover). New patient emergency visits must be in paid in full at the time of the appointment if insurance information is not verifiable.

2. As a courtesy, we will submit your child's claim to the insurance carrier on file for reimbursement if you have assigned the insurance benefits to our office. **Secondary insurance will be filed only if the correct information is provided at the time of service.**

3. You must provide our office with correct dental insurance information at the time of service to include the phone and group number. If insurance coverage cannot be verified, you will be responsible for payment of all fees. We will provide you with a completed claim form for you to submit for reimbursement.

4. If insurance benefits are assigned to the doctor, you will be responsible for paying the deductible and **estimated** co-payments at the time of service. **You are responsible for paying all charges not covered by the insurance company, including all fees considered above the insurance company's usual and customary fee schedule.** Any remaining balances will be billed to you after a claim is paid. Insurance benefits are a contract between the insured and the employer. The amount of coverage received will depend on the type of plan purchased by the employer and is not related to our professional fees.

5. Statements will be mailed to you for all past due accounts. If the account remains unpaid, we may send your information to a collection service to collect payment. There is a **1.5% per month finance charge for accounts over 60 days.** You, the responsible party, agrees to pay all related collection fees. There is a **$25.00 service charge for all returned checks.**

6. Our office will make every **reasonable** effort to obtain payment from your insurance company. If the claim remains unpaid after 90 days, you will be responsible for the remaining balance. Any additional insurance appeals will become your responsibility. We will provide you with any necessary forms, documentation, or receipts.

7. **The parent or legal guardian who brings the child(ren) for their visit is responsible for payment. Regardless of a divorce decree, payment of the entire patient portion is expected at the time of visit. Parents must work out financial arrangements between themselves prior to appointments. Billing statements will not be sent.**

8. In the event that legal action is required as a result of Responsible Party's failure to pay dental fees due under this agreement, Responsible Party agrees to pay 100% of all collection costs, attorney fees, and court costs incurred by this office to collect said fees and costs from Responsible Party.

9. Please keep your child's appointment. We do require a 2 business day notice for any appointment changes to avoid a $50cancellation fee.

10. Doctors may refuse to render future services until outstanding balances have been paid in full.

AUTHORIZATION

1. I authorize Dr. Erin Watts Carpenter, Carpenter Pediatric Dentistry, and staff to release any information concerning my child's dental treatment to my insurance company.

2. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.

_____ _____
Signature of Responsible Party Print Name of Responsible Party

_____
Date

Carpenter Pediatric Dentistry

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 this Notice while it is in effect. This Notice takes effect April, 15, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this 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 this 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 this 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. For example, we may use or disclose your health information to another dentist, physician or other health care provider providing treatment to you.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person involved in your treatment to the extent necessary to help with your healthcare.

Persons Involved In Care: 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 authorized 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.

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 you 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 Notice. If you request copies, we will charge you $0.50 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an 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 this 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 than 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 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You may 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 payments will be handled under the alternative means or location you request.

Amendment: You may request that we amend 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 Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. 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.

Contact Officer: Erin Carpenter
Telephone: (303) 617 - 5437 **Fax:** (303) 617 - 4500
E-mail: info@cpedo.com
Address: 25521 E. Smoky Hill Rd, Ste 210, Aurora, CO 80016

Carpenter Pediatric Dentistry

ACKNOWLEDGEMENT OF RECEIPT 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. I am the legal guardian of the minors listed below.

_____
Please Print Your Name

_____
Signature

_____
Date

_____
Please Print 1st Child's Name

_____
Please Print 2nd Child's Name

_____
Please Print 3rd Child's Name

_____
Please Print 4th Child's Name

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of 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) _____

_____

Child Photo Release Form

☐ I hereby give Carpenter Pediatric Dentistry Permission to use any photos of my child for the purpose of displaying their picture in our Cavity Free Club and their patient chart.

☐ I hereby give Carpenter Pediatric Dentistry permission to use my child's photo for their patient chart only.

☐ I request that Carpenter Pediatric Dentistry Not take my child's photo.

☐ I hereby also give permission for Carpenter Pediatric Dentistry to use my child's photo for marketing purposes.

_____
Please Print Your Name

_____
Signature

_____
Date

_____
Please Print 1st Child's Name

_____
Please Print 2nd Child's Name

_____
Please Print 3rd Child's Name

_____
Please Print 4th Child's Name