WELCOME

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

1. Personal Information

Date _____

Birthdate _____

SS#/SIN _____ Email _____

Name _____

Wishes to be called _____

☐ Male ☐ Female ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address _____

City _____ State/Prov. _____ Zip/P.C._____

Employer _____ Occupation _____

Referred by _____

2. Responsible Party

Who is responsible for the account?

Name _____

Relationship to patient _____

Birthdate _____ Driver's License # _____

SS#/SIN _____ E-Mail _____

Address _____

City _____State/Prov. _____ Zip/P.C. _____

Employer _____

Occupation _____

Work Phone _____ Ext. # _____

Home Phone _____ Cell Phone _____

3. Telephone

Home Phone _____ Work Phone _____ Ext. # _____

Cell Phone _____

Where do you prefer to receive calls? ☐ Home ☐ Work ☐ Cell

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home # _____

4. Dental Insurance Information

Primary Insurance	Additional Insurance
Name of Insured _____	Name of Insured _____
Relationship to patient _____	Relationship to patient _____
Insured's birthday _____	Insured's birthday _____
SS#/SIN _____	SS#/SIN _____
Employer _____	Employer _____
Date Employed _____	Date Employed _____
Occupation _____	Occupation _____
Insurance Company _____	Insurance Company _____
Group # _____	Group # _____
Policy/ID. # _____	Policy/ID. # _____
Ins. Co. Address _____	Ins. Co. Address _____
Ins. Co. Phone # _____	Ins. Co. Phone # _____

5. Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or other health practitioners.

I authorize and request my insurance company to pay directly to the dentist or Dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian if minor Date

6. Financial Arrangements

For your convenience, we offer the following methods of payment.
Please check the option which you prefer.
Payment in full at each appointment.

_____ Cash

_____ Personal Check

_____ Credit Card (Visa, MC, Discover AmExp.)

_____ I wish to discuss the dental office's policy.

Late Charges

If you do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in your being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

Thank you for filling out this form completely. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

High Plains Dental Office Policies

Welcome to our office.

We hope to make your visit comfortable and in doing so, we ask a few things of you.

When cancelling an appointment we would appreciate 24 hours notice. We do understand that there are circumstances that do come up such as weather, sickness, and car trouble when you are unable to give us 24 hours notice. When appointments are missed with little or no notice, these scheduled appointment times cannot be filled. As a result, other patients could have been seen during these times that are exclusively reserved for you and your family members. We appreciate your business and would like to work with you to maintain your dental health, but we also have a commitment to see our patients in a timely manner and the need to utilize our appointment times effectively. Our office has a policy of no more than 3 missed appointments without proper notice.

Our financial policy is payment due in full at the time of visit unless you have made arrangements prior to your dental appointment. We collect co-pays and deductibles at the time of visit unless you have made arrangements prior to your dental appointment. We offer 4 payment options in our office: cash, personal check, credit card, and Care Credit.

Cell phones may be used in our waiting room area only. All cell phones must be turned off or set to vibrate while in our operatories unless you have prior authorization from the doctor or hygienist.

Our policy on nitrous gas is that we do not administer it while any of our staff are pregnant. We do not treat patients with active cold sores, if you have a cold sore you should call to reschedule appointment for a later date.

I acknowledge that I have read and received a copy of High Plains Dental office policies.

Print Patient Name: _____

Relationship to Patient: _____

Patient Signature: _____

Date: _____

669 12th St W
Dickinson, ND 58601
Phone: 701-483-GRIN (4746)

www.highplainsdentalpc.com
info@highplainsdentalpc.com
Fax: 701-483-CARE (2273)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that I can receive your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may withdraw or revoke my permission at any time by notifying High Plains Dental P.C. practice in writing.

In addition to phone calls, how may we confirm your appointments? Please check all that apply.

☐ Text Messages ☐ Email _____

May we leave a message on your answering machine at home or on your cell phone? ☐ YES ☐ NO

May we discuss your medical condition with any member of your family? ☐ YES ☐ NO

If YES, please name the members allowed:

_____

_____

Patient Name (Printed): _____

Relationship to Patient: _____

Signature:_____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

Parent Guidelines

Dear Parents:

You may choose whether or not you accompany your child to his/her filling appointment. Although we sense that some children do better without parents present, we are open to having you with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

1. Allow us to prepare your child
2. Be supportive of the practice's terminology. In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by NOT USING negative words that are often used for dental care. These include:

DON'T USE	OUR EQUIVALENT
needle or shot	**sleepy juice**
drill	**Mr. Whistler/Mr. Bumpy**
drill on tooth	**clean a tooth**
pull or yank tooth	**wiggle a tooth out**
decay, cavity	**sugar bug**
examination	**count teeth**
tooth cleaning	**tickle teeth**
rubber dam	**raincoat**
gas	**magic air**

   This will also help you understand your child's description of the filling experience. Our intention is not to "fool" the child-- it is to create an experience that is positive. We appreciate your cooperation in helping us build a good attitude for your child!

3. Please be a silent observer, support your child with touches
   a. This allows us to maintain communication with your child
   b. Children normally listen to their parents instead of us and may not hear our guidance
   c. You might have incorrect or misleading information
4. If asked to leave, be ready to immediately walk away
   a. Many children will try to control the situation
   b. "Acting out" is normal, but unacceptable during fillings
   c. This is intended to "short circuit" the control attempt
   d. We will continue to support your child at all times

These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines will help prepare you will confidence for the upcoming appointment.

Signed: _____ Date: _____

Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

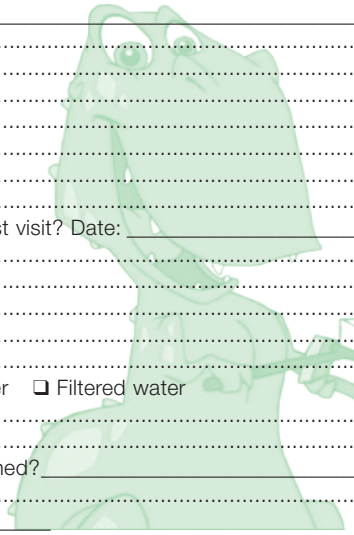
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

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