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 _____ Email _____

Birthdate _____SS# _____-_____-_____Driver's License # _____

First Name _____ Middle Initial _____ Last Name_____

Nickname _____

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

Address _____

City _____State _____Zip_____

Employer _____Occupation _____

Referred by _____

2. Responsible Party

Who is responsible for the account? If same as above, please check here: ❒

Name _____

Relationship to patient: ❒ Parent/Guardian ❒ Spouse ❒ _____

Birthdate _____Driver's License # _____

SS# _____Email _____

Address _____

City _____State _____Zip_____

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

4. Emergency Contact

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

Name _____Relationship _____

Cell # _____Home # _____ Work # _____

5. Dental Insurance Information

Primary Insurance

Name of Insured _____

Relationship to Patient_____

Insured's Birthday _____

SS#_____

Employer _____

Effective Date _____

Occupation _____

Group # _____

Policy/Subscriber ID # _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

Secondary Insurance

Name of Insured _____

Relationship to Patient _____

Insured's Birthday _____

SS#_____

Employer _____

Effective Date _____

Occupation _____

Group #_____

Policy/Subscriber ID # _____

Insurance Co. Address _____

_____

Insurance Co. Phone # _____

6. 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.

_____

Signature of patient or parent/guardian if minor Date

7. Financial Arrangements

For your convenience, we offer the following methods of payment:

PAYMENT IN FULL AT EACH APPOINTMENT.
Please check the option which you prefer.

_____Cash

_____Personal Check

_____Care Credit

_____Credit Card (Visa, MasterCard, Discover)

_____I wish to discuss the dental office's policy.

LATE CHARGES

If you do not pay the entire new balance within 30 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 any time, please ask – we are always happy to help.

Office Policies & Financial Arrangements

We are committed to providing you with the best possible dental care and are pleased to discuss any and all of our professional fees at any time. Your clear understanding of the following information is very important to our professional dental relationship. If you have any questions or concerns, please ask one of our qualified team members.

Payment Options with No Insurance Benefits – Payment in full is due at each appointment. We offer up to 6 months 0% interest free financing available through Care Credit with credit approval. A service charge of 1.5% per month or 18% per year is applied to all balances that exceed 30 days. We also accept cash, check and most credit cards for payments.

Payment Options with Insurance Benefits – We will bill any insurance company, however, it is extremely important that you are familiar with your benefit plan prior to having services rendered. **It is the patient's responsibility to provide insurance plan information or we will be unable to file dental claims on your behalf.** Many insurance companies have a timely filing limit of 90 days, so failure to provide information in a timely manner may result in no payment from the insurance company.

It is important to check your dental benefit plan on a yearly basis as those benefits may have changed from a previous year. Treatment provided in another office during your current plan year may alter your copay due for services in our office. In such cases, we cannot track whether you have reached your yearly maximum benefits. **We do our best to estimate what your insurance company may pay; however, it is ultimately your responsibility and not that of High Plains Dental to know your plan.** Keep in mind; we provide an estimate of benefits and not a guarantee of payment. Your estimated portion is due at the time of service. **Once your insurance company has paid their portion, any remainder balance is due in full within 30 days.** All charges not paid by your insurance company are your responsibility, regardless of the reason for non-payment. **If your insurance company has not paid your claim within 90 days of services rendered, you will need to remit payment in full to the office.** You will be reimbursed when we receive payment from your insurance company. After 90 days, it will be the patient's responsibility to actively pursue payment from their insurance company.

Limited Exams – We will be happy to make an appointment for you to take care of your treatment needs. For limited exams, payment will be collected IN FULL at the time of service. Our policy is that we will see a patient for two limited exam appointments in our office and complete the recommended treatment associated with the exam. After two limited exam appointments, you must become an established patient by having a comprehensive exam and regular dental cleanings to continue being seen in our office.

Broken Appointments/Short Notice Cancellations – Appointments are reservations made for you, therefore, we request a 24-hour notice if you are unable to keep your scheduled appointment. We do understand that there are circumstances that come up such as weather, sickness, and car trouble when you are unable to give us 24 hours notice. Appointments are reserved exclusively for you. 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 three missed appointments without proper notice.

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

Cold Sores – We do not treat patients with active cold sores, if you have a cold sore you should call to reschedule your appointment for a later date.

Nitrous Oxide Gas – Our policy on nitrous oxide gas is that we do not administer it while any of our staff are pregnant and working. We will set aside specific times for Nitrous Oxide gas administration if there are staff members that are pregnant.

Minor Patients – In the case of divorced or separated parents, it is your responsibility to have financial arrangements made before the treatment begins. Payment for services of minors is the responsibility of the adult accompanying the minor and is due at the time of service.

Consent & Authorization – I authorize dental treatment on myself or my child and agree to pay all related fees. Fees not covered by my dental insurance will be promptly paid upon notification from this office. Please indicate your understanding and acceptance of these office and financial policies by signing below.

_____	_____	_____	_____
Printed Patient Name	Patient Date of Birth	Signature of Patient/Legal Guardian	Date

If you are filling this out for a minor, are you the person legally responsible? ❑ Yes ❑ No

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:

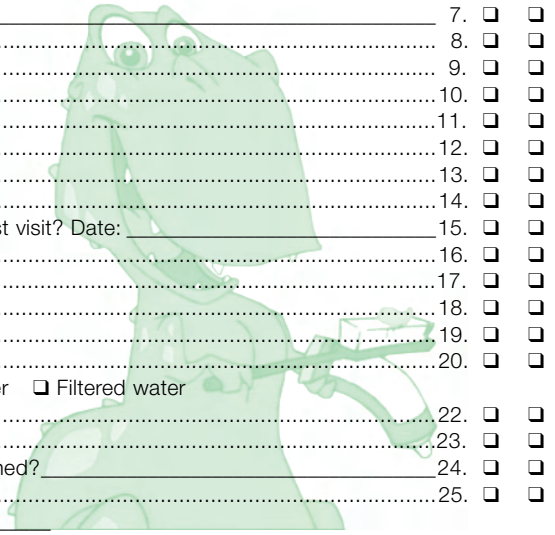
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic 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

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org