CUIVRE CREEK
PEDIATRIC DENTISTRY

Patient Information

Child's Name: _____ **Child's DOB:** _____

Preferred/Nickname (If Applicable): _____ **Male** ☐ **Female** ☐

Parent's Name: _____ **Parent's Name:** _____

Parent's DOB: _____ **Parent's DOB:** _____

Parent's SSN: _____ **Parent's SSN:** _____

Social notes (adoption, guardianship, etc.) if applicable: _____

Cell phone number: _____ **Other phone number:** _____

Email Address: _____

Home address: _____

City: _____ **State:** _____ **Zip Code:** _____

Favorite activities/hobbies/pets: _____

How did you hear about us?

☐ Referred by friend ☐ Drive by ☐ Google ☐ Facebook

☐ Referred by a dentist ☐ Referred by medical doctor ☐ Other: _____

Insurance Information

Primary Dental Insurance		**Secondary Dental Insurance (If Applicable)**	
Name of Insured:		Name of Insured:	
DOB:		DOB:	
SSN:		SSN:	
Employer:		Employer:	
Phone:		Phone:	
Insurance Company:		Insurance Company:	
Company Phone:		Company Phone:	
Group/Policy #		Group/Policy #	
ID #		ID #	

Cuivre Creek Pediatric Dentistry (P) 636-383-4500 (F) 636-383-4501 www.troypediatricdentist.com

CUIVRE CREEK
PEDIATRIC DENTISTRY

MEDICAL HISTORY

□ Yes □ No Has your child ever had any health problems? _____

□ Yes □ No Were there any difficulties at birth? _____

□ Yes □ No Does your child have any allergies? _____

□ Yes □ No Are your child's immunizations current?

□ Yes □ No Have you ever been told that your child needs to take antibiotics before dental treatment?

□ Yes □ No Has your child ever been hospitalized, had general anesthesia, or previous surgeries? Please explain:

_____

Medications your child is taking: _____

Child's physician and clinic: _____

Child's Height: _____ Child's Weight (lbs): _____

Please check if your child currently has, or been treated for any of the following:		
□ Allergic reaction	□ Cerebral palsy	□ Kidney disease
□ ADD/ADHD	□ Cleft lip/palate	□ Mental or behavior delays
□ Anemia	□ Congenital birth defect	□ Physical or growth delays
□ Anxiety or depression	□ Diabetes or endocrine problem	□ Seizures or neurological problem
□ Asthma or respiratory	□ Gastro-intestinal issue	□ Snoring or sleep apnea
□ Autism spectrum	□ Genetic syndrome	□ Speech or hearing problem
□ Bleeding disorder	□ Heart problem or congenital defect	□ Tonsils or adenoids
□ Cancer/chemo/radiation	□ Infection	□ Tobacco or substance abuse
□ Other, or please expand further:		

Dental HISTORY

What brings you to our office today? _____

□ Yes □ No Has your child ever seen a dentist, and if so, when? _____

□ Yes □ No Were x-rays or other treatment completed? _____

□ Yes □ No Any existing dental conditions or concerns?_____

□ Yes □ No Is your child having tooth pain? _____

□ Yes □ No Has your child experienced dental trauma? _____

□ Yes □ No Does your child have any oral habits (thumb, pacifier)? _____

Please describe home hygiene/brushing: _____

Please describe fluoride exposure: _____

Do you have any concerns or special requests for Dr. Casey? _____

How do you anticipate your child will behave for today's appointment?

□ Cooperative □ Anxious, but probably cooperative □ Uncooperative or crying □ Unsure

Cuivre Creek Pediatric Dentistry (P) 636-383-4500 (F) 636-383-4501 www.troypediatricdentist.com

CUIVRE CREEK
PEDIATRIC DENTISTRY

Consent for Treatment and Release of Protected Health Information

I give my consent for Dr. Casey Goetz at Cuivre Creek Pediatric Dentistry to examine, clean, diagnose, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Casey Goetz to diagnose and/or treat my child's dental needs. I understand and approve for the doctor and staff at Cuivre Creek Pediatric Dentistry to use appropriate behavior management strategies in order to safely guide patient behavior and complete the needed dental work. This may include using positive reinforcement, explanation, and using variable voice tone and body language.

Initial: _____

Please review our Notice of Privacy Practices on the last page before signing this consent. By initialing below, I authorize Cuivre Creek Pediatric Dentistry to disclose my child's protected health information (PHI), which may include sending films and/or reports containing my child's PHI (consisting of name, date of birth, medical history, clinical notes, radiographs, etc.) to any other physicians or healthcare providers that request or require this information to perform treatment and/or consultation regarding my child's dental health. To facilitate the filing of my dental insurance claims, I also authorize the release of PHI to my dental insurance agency and any of their representatives. I authorize Cuivre Creek Pediatric Dentistry to leave voicemail, email, and text messages to confirm, change or notify me of my appointment, unless specifically requested otherwise. I understand that these messages may contain PHI about my child.

Initial: _____

Failed Appointment Policy

We strive to provide excellent dental care to all of our patients and reserve time on Dr. Casey's schedule specifically for your child. To be fair to all patients wanting to be seen here, we require advanced notice of changes so unused appointment time can be offered to another patient. In the event that we are not given **Two Business Days' notice for a cancellation**, we may not be able to reschedule your child or your family at our office in the future. **A failed appointment without calling our office may be grounds for dismissal from the practice.**

Initial: _____

Accompany Minor

The following individuals may accompany and/or authorize dental treatment for this minor patient, and act on my behalf to make health care decisions. I understand that Cuivre Creek Pediatric Dentistry reserves the right to postpone the delivery of certain treatments when a legal guardian is not present.

Name	Relationship to Patient	May authorize a change in treatment
		YES/NO
		YES/NO
		YES/NO

Parent/Legal Guardian Signature: Relationship to Child: Date:

Cuivre Creek Pediatric Dentistry (P) 636-383-4500 (F) 636-383-4501 www.troypediatricdentist.com

CUIVRE CREEK
PEDIATRIC DENTISTRY

Financial Agreement Reminder

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and/or the insurance company. Our practice is not a party to that agreement. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all of your insurance claims. You may direct your insurance company to pay your benefits directly to our practice by signing the authorization on the Assignment of Benefits Agreement. In order for our practice to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

We do our best to create an accurate treatment plan estimate prior to the scheduled appointment, but sometimes treatment can change during the course of the appointment. Your estimated copayment for treatment, which is the amount not covered by your insurance, is due in full at the beginning of the appointment, prior to bringing the patient back to the operatory. Your estimated copayment may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. If your insurance ends up paying a different amount than what was collected, either a bill or a refund will be sent. Our practice accepts cash, credit/debit card, and checks.

Returned checks and balances older than 60 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing your child with the highest level of dental care possible.

Parent/Legal Guardian Signature: Relationship to Child: Date:

Cuivre Creek Pediatric Dentistry (P) 636-383-4500 (F) 636-383-4501 www.troypediatricdentist.com

CUIVRE CREEK
PEDIATRIC DENTISTRY

Patient Photo Release Form

If declining consent to have photographs taken of your child, please leave this section blank.

I hereby authorize Cuivre Creek Pediatric Dentistry to take photographs or videos of my child's teeth, jaws, and face. I understand that the photographs, slides, radiographs, and/or videos may be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures.

The content may also be used for advertising purposes (including website publication, Facebook posts, Instagram, etc). I further understand that if the photographs, slides, radiographs, and/or videos are used in any publication or presentation, my child's identifying information (name) will not be used unless permission is given to do so. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

Please initial any of the following that you consent to:

_____ I consent for my child's photographs to be used for medical documentation.

_____I consent for my child's photographs to be used for marketing purposes/social media.

Signed: _____ **Date**: _____

Cuivre Creek Pediatric Dentistry (P) 636-383-4500 (F) 636-383-4501 www.troypediatricdentist.com

CUIVRE CREEK
PEDIATRIC DENTISTRY

NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing healthcare and related services by one or more health care providers. An example of this would include teeth cleaning services.
- Payment includes, but is not limited to, activities such as: obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Healthcare operations are the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all reference to an individual or any individuals. We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. All other uses and discloses will be made only with your written authorization. You may revoke the authorization in writing and we are required to honor and abide by that written request, except in relation to disclosures made prior to that date.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses, and disclosures, of protected health information, including information disclosed to family members, other relatives, close personal friends, or any other person you identify. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of September 1st, 2020 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint to our Privacy Officer, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please contact us at Cuivre Creek Pediatric Dentistry for more information. For more information about HIPAA or to file a complaint, contact the US Department of Health and Human Services Office of Civil Rights at (202)-619-0257 Toll Free: 1-(877)-696-6775.