## Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Email Address: _____ Gender: _____

Social Security #: _____ Birth Date: _____

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

Preferred appointment times: ☐ Morning ☐ Afternoon ☐ Evening ☐ Any Time ☐M ☐T ☐W ☐T ☐F ☐S

Address: _____
Street Apartment #

_____
City State Zip Code

## Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

***Have you ever had any of the following? Please check ALL that apply:*** ☐ None apply

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ☐ | ☐ | AIDS | ☐ | ☐ | Epilepsy | ☐ | ☐ | Kidney Disease | ☐ | ☐ | Stomach Problems |
| ☐ | ☐ | Allergies | ☐ | ☐ | Excessive Bleeding | ☐ | ☐ | Liver Disease | ☐ | ☐ | Stroke |
| | | _____ | ☐ | ☐ | Fainting | ☐ | ☐ | Mental Disorders | ☐ | ☐ | Tuberculosis |
| | | _____ | ☐ | ☐ | Glaucoma | ☐ | ☐ | Nervous Disorders | ☐ | ☐ | Tumors |
| ☐ | ☐ | Anemia | ☐ | ☐ | Growths | ☐ | ☐ | Pacemaker | ☐ | ☐ | Ulcers |
| ☐ | ☐ | Arthritis | ☐ | ☐ | Hay Fever | ☐ | ☐ | Pregnancy | ☐ | ☐ | Venereal Disease |
| ☐ | ☐ | Artificial Joints | ☐ | ☐ | Head Injuries | | | Due date:_____ | ☐ | ☐ | Codeine Allergy |
| ☐ | ☐ | Asthma | ☐ | ☐ | Heart Disease | ☐ | ☐ | Radiation Treatment | ☐ | ☐ | Penicillin Allergy |
| ☐ | ☐ | Blood Disease | ☐ | ☐ | Heart Murmur | ☐ | ☐ | Respiratory Problems | OTHER: | | |
| ☐ | ☐ | Cancer | ☐ | ☐ | Hepatitis | ☐ | ☐ | Rheumatic Fever | ☐ | | _____ |
| ☐ | ☐ | Diabetes | ☐ | ☐ | High Blood Pressure | ☐ | ☐ | Rheumatism | | | |
| ☐ | ☐ | Dizziness | ☐ | ☐ | Jaundice | ☐ | ☐ | Sinus Problems | ☐ | | _____ |

- Please list any medication that the patient is currently taking: _____
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- Do you smoke or use any tobacco products? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____

Doctors Initials

## Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

## Parent or Responsible Party Information

The following is for: ☐ the patient's parent/ legal guardian ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

E-mail: _____

Social Security #: _____ Birth Date: _____

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

Address: _____
Street Apartment #

_____
City State Zip Code

## Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

## Insurance Information

**Primary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

**Secondary**

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

**Pediatric Dental Treatment Consent Form**

As health professionals, it is necessary that we inform our patients and parents of all the possible treatment and techniques that we use in our office. Please read this form carefully and ask any questions that may not be clear, or that you may not understand.
***This is only to inform you of the types of services we provide, which varies from child to child and according to their needs. We will ALWAYS advise you of any and all treatment that will be completed before we render ANY services. The care of your child is our top priority.***

1. Please mark you initials next to each item to confirm that you have read and understand each item listed below and are aware that these are only services that we offer and that these services and techniques are NOT NECESSARILY something that your child will need:
   A. _____ Dental cleaning, fluoride application, and radiographs, as necessary
   B. _____ Application of sealants to dental fissures
   C. _____ Restoration of broken teeth or fillings
   D. _____ Treatment of infected teeth or gums
   E. _____ Removal of 1 or more teeth
   F. _____ Use of "Voice Control" to gain your child's attention during dental procedures
   G. _____ Use of a "Safety Blanket" to protect your child from injury during certain procedures
   H. _____ Use of local anesthetics
   I. _____ Use of sedative drugs for the control of nervousness or negative behavior
   J. _____ Use of Nitrous Oxide to help reduce anxiety
   K. _____ Use of oral sedation and the associated risks of these types of anesthesia
   L. _____Tenderness, bruising, nausea, vomiting, aspiration, swelling, bleeding, infection, numbness, allergic reaction, stroke, heart attack, and death are all possible complications of ANY dental procedure. Some of these complications may require hospitalization. Serious complications are *EXTREMELY* rare.

Although the best results are always expected, there is no way within reason of anticipating complications. Therefore, it is not possible to guarantee the results, or cure, of the treatment. Although the occurrence is remote, it is known that some risks are associated with dental procedures. We are required to mention the following: damage to central nervous system, reduction or loss of function of internal organs and limbs, as well as disfiguring scars. I understand and accept that certain complications may be fatal or require medical intervention and that the staff at Wild West Children's Dentistry places the safety of our patients above anything else.

_____ Date: _____
Signature of patient, parent or guardian

# Child Safety Procedures Policy

Often we are asked by parents “Why can’t I remain with my child during dental procedures?” To help you understand better, we offer the following reasons:

1. A child’s behavior is more in control without parental emotional involvement.
2. A sedated child requires the full attention of the staff and doctor. Visitors in the room can cause distractions and the doctor/assistants need to have their full attention on your child.
3. Parents in the examination room often slow procedures with questions, concerns, and helpful suggestions. Due to some procedures, parents may not have the stomach to observe, leading to fainting and vomiting.
4. The child needs to know that the Doctor is the authority figure. When parents or other adults are in the room, this authority is undermined. This can lead to longer appointment times and confusion for the child.
5. The rooms are small with expensive, sensitive equipment.

We are an office dedicated to the quality treatment of children; please know that our office mission is to treat every child as if they were our own. We follow the same parental procedures regardless of sedation level required. There are no exceptions.

Thank you for your understanding,
Wild West Children’s Dentistry Doctors and Staff

_____ Date: _____
Signature of patient, parent or guardian

# Financial Policy

## Insurance and Patient Payments

If you have informed us, "Wild West Children's Dentistry", of the insurance policy that you carry, we will gladly process your forms for you. At your first appointment with us, we will gladly give you an ***estimate*** of what your insurance will cover and what your out-of-pocket portion will be. Your ***estimated*** portion will be due at the time when the services are rendered. Your ***insurance carrier*** makes it very clear that they ***will not guarantee any payment*** until the services are billed and reviewed. Please remember that our contracts for your child's dental services are with you and not your insurance carrier. We allow 45 days from the date of service for payment from your insurance carrier. After this period, we will expect payment in full for any unpaid dental services.

### Fillings

Composite, or "white" fillings, are the only type of fillings done here at Wild West Children's Denistry. Your insurance may only give you the benefit of the Amalgam, or "Silver", fillings. This means that you may be responsible for the difference, or the dollar amount cost difference, between the two. Please contact your insurance company with any questions regarding this coverage.

## Cancelled/ Missed Appointments

We reserve the right to charge $25.00 for appointments cancelled or missed without a 24 hour advanced notice.

## Finance Charges

We reserve the right to charge 1.5% finance charge monthly on any outstanding/unpaid balances over 30 days.

## Collection Policy

We reserve the right to assign any dental account that is unpaid for more than 90 days to a collection agency. The guarantor, or parent, is allowed 3 written statements and at least one call, by law. If a payment arrangement is not made after contact attempts, any and all unpaid charges, including any late or finance charges, will be assigned to a collection agency. An additional 37% collection fee may apply. It is further agreed that the guarantor, or parent, will be responsible for all finance charges, collections costs, attorney fees, and any other costs that may be incurred to enforce collection of any amount outstanding.

## Return Check Policy

We reserve the right to charge $35.00, or the maximum amount allowed by the Arizona State Attorney General's office, for all NSF checks returned to Wild West Children's Dentistry.

**By signing below I agree that I have read and clearly understand all of the above policies.**

_____ Date: _____

Signature of patient, parent or guardian

_____ Date: _____

Witness

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Wild West Children's Dentistry is to serve our patients with professionalism and caring, being sure at all times to PROTECT the privacy and security of all Protected Health Information.
During the course of serving you interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared.

During treatment, we may find it necessary to consult with a dental laboratory. For payment purpose, we may use the service of billing service. During dental care, we may need to consult with your physician or previous dentist. For payment purpose, we need to supply information requested from your dental insurance company.

We here at Wild West Children's Dentistry are committed to obeying all Federal, State, and local laws and regulations regarding Privacy Practices. If any uses of disclosures, other than the ones listed above, are needed, information will only be released with the written authorization of the individuals in question. The individual, as provided by law, may revoke this written authorization at any time.

If you have questions or comments regarding your Protected Health Information, feel free to contact our Office Manager at (602) 418-1599.

**I have read and understand the above NOTICE OF PRIVACY PRACTICES.**

_____ Date: ____
Signature of patient, parent or guardian