About your child

Child's full name:

_____

□ male □ female

Date of birth _____ age _____

How did you hear about us?

_____

Dental history

Is this your child's first dental visit □ Yes □ No

Previous dentist:

_____

Date of last visit: _____

Any injuries to child's face or jaw?

_____

History of:

Thumb sucking □ past □ present

Pacifier use □ past □ present

Teeth grinding/clenching □ past □ present

Other habits: _____

Has your child had any unpleasant experiences or an unfavorable reaction to previous dental care? □ yes □ no

If yes, please explain:

_____

_____

Who is responsible for brushing child's teeth?

_____

Brushing : □ AM □ PM □ Both

Fluoride and Dietary Assessment

Does your child use fluoride toothpaste? □ yes □ no

Does your child take prescription fluoride? □ yes □ no

Has your child received Fluoride treatments before? □ yes □ no

Is your child a good eater? □ yes □ no

Does your child drink:

□ juice □ milk □ soda □ energy drinks

Is your child breast feeding? □ yes □ no

Is your child using a bottle or sippy cup? □ yes □ no

Medical History

Does your child require antibiotics prior to dental treatment due to a heart defect or other medical conditions? □ yes □ no

Is your child allergic to latex, dyes or metals? □ yes □ no

List: _____

Is your child allergic to any medications? □ yes □ no

Please list all allergies:

_____

_____

_____

Is your child taking any medications? □ yes □ no

List: _____

_____

Pediatrician/physician:

_____

Phone: _____

Date of last check up: _____

Is your child currently under the care of a physician or specialist for any reason?

□ yes □ no

For:_____

_____

Does your child have, ever had, or been diagnosed with any of the following? Check all that apply.

__ Asthma

If yes, what are the triggers?

_____

__ Anemia
__ Autism
__ Bladder conditions
__ Blood disease
__ Blood transfusion
__ Birth defects
__ Bone or joint problems
__ Brain injury
__ Bruising easily
__ Cancer or malignancies
__ Cerebral palsy
__ Chemotherapy radiation
__ Child abuse
__ Chronic ear infections
__ Chronic headaches
__ Cleft palate/lip
__ Congenital hearth lesion
__ Convulsions/Seizures
__ Developmentally delayed
__ Diabetes
__ Drug addiction
__ Emotional disturbance
__ Epilepsy
__ Eye problem
__ Excessive bleeding
__ Excessive gagging
__ Fainting or dizziness
__ Fever blister/cold sores
__ Growth problems
__ Heart surgery
__ Hearing/speech impediment
__ Heart murmur/defect
__ Hemophilia
__ Hepatitis or liver disease
__ High blood pressure
__ HIV
__ Hyperactivity/ADHD
__ Kidney disease
__ Leukemia
__ Neurological problems
__ Nutritional deficiency
__ Orthopedic problems
__ Pain in jaw joints
__ Premature birth
__ Psychiatric care
__ Respiratory disease
__ Rheumatic fever
__ Sensory integration disorder
__ Shunts

If needed, please describe any checked items further:

_____

_____

_____

_____

Do you wish to speak with the doctor privately about special concerns? □ yes □ no

Does your child have any other condition not listed on this page?

□ yes □ no

List:_____

_____

_____

_____

Parent/Guardian information

Father:

_____

Mother:

_____

Step parent:

_____

Legal Guardian:

_____

□ Married □ Single □ Divorced □ Widowed

Home address of responsible party:

_____

_____

City and **zip code**:

_____

Work phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

Insurance Information

Insurance company and employer:

_____

Subscriber/Policy holders name:

_____

Relationship to child:

_____

Subscriber/Policy holder's DOB:

_____

Subscriber/ Policy holder's social security #:
(If your child has Colorado health OP, list their social security number).

_____

ID #: _____

Group #: _____

Does this child have Medicaid? □ yes □ no

Medicaid #: _____

Secondary insurance information

Insurance Company and employer:

_____

Subscriber/Policy holders name:

_____

Relationship to child:

_____

Subscriber/Policy holder's DOB:

_____

Subscriber/ Policy holder's social security #:
(If your child had Colorado health OP, list their social security number).

_____

ID #: _____

Group #: _____

Authorization

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that payment is due at the time services are rendered. I hereby authorize payment directly to Golden Kids Dental and Orthodontics from any insurance company listed above. I agree to payment of any co-pays, deductibles, and uncovered services or amounts. I authorize the release of any dental information necessary to process insurance claims or for determination of benefits. If my account requires servicing for collection, I understand that I will be liable for all fees incurred.

Signature:_____

Today's date: _____

Vital information about your Dental Insurance

Insurance companies set their own schedules, and each company uses a different set of fees they consider allowable. When estimating dental benefits, deductibles and percentages must be considered. If we have received all of your insurance information and you have kept us current on any insurance changes, we will be happy to file the claim for you. Please be familiar with your insurance benefits, as this is a contract between you and the insurance company. We will collect from you the estimated amount insurance is not expected to pay at the time of service. By law your insurance is required to pay each claim within 30 days of receipt. We file insurance claims electronically, so your insurance company will receive each claim within days.

Cancellation policy

Cancellations require a 24 hour notice. We reserve the right to charge $25.00 per child for not giving such notice. While we understand that circumstances happen that can cause you to cancel, please understand that we cannot fill a cancelled spot last minute.

Consents for treatment and release of information

I give the doctor permission to use such measures as deemed necessary in his/her professional judgment to render a diagnosis for my child and to perform treatment. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I understand that dental treatments are meant to help save my child's teeth, but it is not guaranteed. When a treatment plan is put together, I understand that treatment may not go in order of the written plan. I understand treatment is done in the order that is best for the patient and that treatment may change if necessary once a procedure has started.

I have given an accurate report of my child's physical and mental health history. I have also reported any proper allergic or unusual reactions to drugs, food, skin or any other physical conditions that my child's medical doctor has advised me should be reported to the dentist.

I understand and consent to x-rays and other protected health information being sent via email for the purpose of referrals, treatment and collection from insurance.

Responsible party signature: _____ dated: _____

Acknowledgement of receipt of Notice of Privacy Practices

I, _____ (check one of the following)

□ I have read and I have received a copy of this office's Notice of Privacy Practices

□ I have printed and signed a copy of this office's Notice of Privacy Practices form the Golden Kids Dental and Orthodontics website.

□ I have read this office's Notice of Privacy Practices and do not wish to have a copy.

Signature: _____ date: _____

-Below is for office use only-

□ Individual refused to sign □ Communication barriers prohibited obtaining acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement □ Other (specify)

Notice of Privacy Practices

This notice describes how health information about your child may be used and disclosed and how you can get access to this information.

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 01/01/2014 and will remain in effect until we replace it. You may request a copy of our notice at any time.

Uses and disclosures of health information

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to your child.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioners and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. 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. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

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 to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your

healthcare. We will also use our professional judgment and our experience with common practices 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: 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 your child is 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 authorize 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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 for request of records release from us.

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.

Restrictions: You have the right to 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 Communications: 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 have the right to request that we amend your health information. (Your request must be in writing, and must explain why the information should be amended).

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (email), you are entitled to receive this Notice in written form.