COPPER COVE

PEDIATRIC DENTISTRY

Childs Name: First _____ Last _____ ◯Male ◯Female
Birthdate: _____ Age: _____ School: _____
Home Address: _____
City, State, Zip Code: _____
Child lives with: ◯Father ◯Mother ◯Both ◯Other Who:_____
Marital Status: ◯Married ◯Single ◯Divorced ◯Separated ◯Widowed

Mother:_____ Home #: _____ Cell #: _____
Social Security #: _____ Birthdate: _____
Mother Employer: _____ Work #: _____
Home Address (if diff. than child): _____

Father: _____ Home #: _____ Cell #: _____
Social Security #: _____ Birthdate: _____
Father employer: _____ Work #: _____
Home Address (if diff. than child): _____

Name of Legal Guardian: _____ Phone #: _____

Name of relative **NOT** living with you that we may contact in case of an emergency:
_____ Phone #'s: _____

Primary Dental Insurance:
Name: _____
Subscriber: _____

Secondary Dental Insurance:
Name: _____
Subscriber: _____

Health Medical Insurance: Name: _____
Subscriber: _____ ID#: _____

Referral Information:
Whom may we thank for referring you to our office?
Hometown Values ◯ Internet ◯ Insurance ◯ Sign Outside ◯ Other ◯
Friend or Family ◯ Name:_____ __

EMAIL ADDRESS: _____

Dental History:

Why is your child here today? _____

Has your child been seen by a dentist before? ◯Yes ◯No

How often does he or she brush/floss? _____

Is your child currently on a bottle/pacifier/sippy cup/or nursing? _____

Medical History:

Name of Physician: _____ Phone: _____

Is your child currently taking any medications? _____

Is your child currently under the care of a physician for any reason? If yes, why?

_____

Has your child ever been hospitalized? ◯Yes ◯No

Date: _____

Has your child ever had a traumatic dental injury? ◯Yes ◯No

Date: _____

DOES YOUR CHILD HAVE OR PREVIOUSLY HAD ANY OF THE FOLLOWING?

(please circle all that apply to your child)

ADHD	Y ☐	Endocrine System	Y ☐	Rheumatic Fever	Y ☐
AIDS	Y ☐	Fainting	Y ☐	Seizures	Y ☐
Allergies	Y ☐	GI System	Y ☐	Tuberculosis	Y ☐
Anemia	Y ☐	Head Injury	Y ☐	Vomiting/Diarrhea	Y ☐
Artificial Joints	Y ☐	Freq. Headaches	Y ☐		
Asthma	Y ☐	Heart Condition	Y ☐	Allergies/Adverse Reaction	
Autism	Y ☐	Heart Murmur	Y ☐	To Medications: _____	
Behavioral Disorder	Y ☐	Kidney Disease	Y ☐	_____	
Blind/Deaf	Y ☐	Liver Disease	Y ☐	_____	
Blood Disease	Y ☐	Mental Disorder	Y ☐		
Blood Transfusion	Y ☐	Mental/Physical		Frequent Infections: _____	
Cancer/Tumor	Y ☐	Development Delay	Y ☐	_____	
Congenital Birth		Pregnancy	Y ☐	_____	
Defects	Y ☐	Due Date:_____			
Down Syndrome	Y ☐	Radiation Treatment	Y ☐	Any additional medical	
Multiple Ear		Respiratory Problems	Y ☐	conditions not listed:_____	
Infections	Y ☐	Respiratory		_____	
Tubes in Ears	Y ☐	Treatment	Y ☐	_____	

I have read the above and have answered them to the best of my knowledge. I have updated this form as requested.

Signature: _____ Date: _____

Signature (updated info): _____ Date: _____

COPPER COVE

PEDIATRIC DENTISTRY

Cancellation/No-Show Policy:

We realize your time is valuable and make every effort to keep you from waiting. As a result, your appointment time in this office is reserved exclusively for you!

We require 24 hours notice to *cancel* or *reschedule* your appointment. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

Failure to be present at the time of a reserved appointment will be recorded in your patient chart as a "no-show". The first no-show will be no charge; we realize that emergencies, family obligations, and illnesses do occur. If there is a second no-show a **$35** fee will be billed to your account, a third no-show a $35 fee will be billed to your account, a fourth no-show will result in suspension of services and dismissal from our dental practice.

We understand that delays can happen however we must try to keep the other patients and doctors on time. This policy is in effect for all appointments at our office.

Please acknowledge that you have had the opportunity to review this policy by signing below.

FAMILY NAME:_____

Signature:_____Date:_____

Copper Cove Pediatric Dentistry
FINANCIAL AGREEMENT

If the patient does not have dental insurance, payment in full is expected on the day of service. If the patient does have dental insurance, the responsible party will pay the patient **estimated** portion and deductible on the day of service. The insurance will be billed as a courtesy; however (please be aware), if the insurance does not pay within 60 days, payment in full is expected from the responsible party.

Because it is your insurance, you are ultimately responsible for knowing and executing the requirements of your insurance. We strongly suggest you call your insurance to verify your plan. **No insurance company will guarantee an exact payment.** Please keep in mind that all insurances relay a disclaimer that states they are only giving general information when we call to check on your benefits.

We will do everything we can to assist you in obtaining the maximum of your insurance plan. However, the insurance is a **contract between you and your insurance carrier**. Therefore, **you are ultimately responsible for payment in full of your account**.

I understand that insurance companies pay on a usual and customary fee schedule and that the fees charged by the Doctor are the actual fees. I am responsible for all differences between the Doctor's fee and the insurance fee. I understand the Doctor will be using white filling material and some insurance companies will reduce the fee to a silver filling rate. It is my responsibility to pay the difference, if any, between the two fees. I understand that every 6 months my child will have a full exam, x-rays, prophylaxis, and fluoride treatment. If my insurance does not cover it that often, **it is my responsibility to let the staff know before my child goes back for their appointment.** I understand that if my child has been referred by another Dentist, my insurance may not cover the cost of the exam or x-rays due to the plan limitations and it is my responsibility to pay.

When scheduling work with an oral sedation, I understand that my insurance will not cover this charge. **Sedation fee of $150 is due in full along with all estimated dental co-payments on the date of service.**

There will be a **$25 returned check fee** assessed to your account on all returned checks. There will be late fees, certified letter fees, rebilling fees, and finance charges added to all accounts after 60 days late. Credit checks will be obtained with all financial arrangements that are not paid in full on the date of service. The responsible party agrees to pay all attorney fees and court costs associated with collecting payment for the services rendered. Collection fees of 33.3% are added to the account when it is turned over to the agency.

I have read and understand the above policy and agree to abide by them.

Signature Date

Copper Cove Pediatric Dentistry

Patients Name:_____

Consent to proceed:
I authorize Dr. Troy Hardy DMD, Dr. Adam Bushell DDS, and/or such associates or assistants as he may designate to perform those procedures as may be necessary or advisable to maintain my dental health or the dental health or any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative including but not limited to nitrous oxide, general anesthesia, analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, pallative, therapeutic, and/or surgical treatments. I understand that the administration of local anesthetic may cause an adverse reaction or side effects, which may include, but are not limited to, bruising, hematoma, cardiac stimulation, and temporary or rarely, permanent numbness, and muscle soreness. I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me the necessary and I have given the opportunity to ask questions.

_____

Signature (parent or legal guardian) Date

The Responsible party agrees to:
I grant permission to the dentist to perform any necessary dental work needed for this child. **Patients with insurance MUST pay their ESTIMATED portion, including deductible at the time of service.** Please note we submit your insurance as a courtesy to you, it is your responsibility to see the insurance makes prompt payment. Any unpaid insurance over 60 days is due and payable by the responsible party. I also agree to pay my balance within 90 days or the account will be turned over to an outside collection agency. In the event of default, I agree to pay interest of 18% APR, and the cost of any late fee, certifies letter fee, rebilling fee, and or collection fee's of 33.3% of my account balance, and the cost of reasonable attorney fees. Credit check will be obtained on accounts that need financial arrangement, that are not paid in full on date of service.

_____

Signature (parent or legal guardian) Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that the information can be used to, but are not excluded 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 certifications

I have received, read and understand 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 the Notice of Privacy Practices from time to time and that I may conduct this organization at any time at the address above to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my privacy 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.

Patients Name_____

Name of Parent of responsible party_____

Relationship to Patient_____

Signature_____

Date_____

SUBMIT FORM

Office use only

I attempted to obtain patient's signature in acknowledgment of this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below.

Date_____Initials_____Reason_____