Child Medical History

Patient's Name:_____ **Birthdate**:_____ **Preferred Name**:_____

Parent or Guardian's Name: _____ Relationship to Patient: _____

Parent Phone: _____ **Email Address**_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you may have, or medications that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Name of Child's Physician: _____ Physician Phone:_____

Is your child currently under the care of a physician? ☐ Yes ☐ No

If yes, explain: _____

Has your child ever been hospitalized or had a major operation? ☐ Yes ☐ No

If yes, explain: _____

In Case of Emergency Contact: _____ Relationship: _____ Phone: _____

How did you hear about our Office? _____

Does your child have or have they had any of the following?

- ☐ AIDS/ HIV Positive
- ☐ Allergies
- ☐ Anemia Chronic
- ☐ Arthritis
- ☐ Asthma
- ☐ Bladder Issues
- ☐ Bleeding Disorder
- ☐ Bones/Joints
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Coagulation Disorder
- ☐ Congenital Heart Defect
- ☐ Depression
- ☐ Diabetes
- ☐ Ear Aches
- ☐ Epilepsy or Seizures
- ☐ Fainting
- ☐ Growth Problems
- ☐ Hearing Impaired
- ☐ Heart Issues
- ☐ Hepatitis
- ☐ Immunizations
- ☐ Kidney Disorder
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Measles
- ☐ Mononucleosis
- ☐ Mumps
- ☐ Organ Transplant
- ☐ Psychiatric Care
- ☐ Respiratory Problems
- ☐ Rheumatic Fever/Rheumatic Heart Disease
- ☐ Sinus Problems
- ☐ Spina Bifida
- ☐ Stomach Problems
- ☐ Thyroid Issues
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease

Does your child have any condition or disease that is not listed above? ☐ Yes ☐ No

If yes, please explain: _____

List any **Medications, Over the Counter Medications, Supplements or Herbs** that your child is currently taking:

Prescriptions Meds	Over the Counter Meds	Supplements	Herbs
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Is your child allergic to any medications? ☐ Yes ☐ No If yes, please list:_____

Is your child Allergic, or have they reacted adversely to any of the following?

☐ Acrylic ☐ Aspirin ☐ Codeine ☐ Latex ☐ Local Anesthetics ☐ Metal ☐ Penicillin ☐ Sulfa Drugs

☐ Tetracycline ☐ Other _____

Has your child ever received cancer treatment?: ☐ Yes ☐ No

Dental History

Reason for today's visit? _____

Is your child experiencing any dental pain today? ☐ Yes ☐ No

If yes, explain:_____

Date of last Dental Visit:_____ **Date of last Dental Cleaning:** _____

Infants: Is your child breastfeeding or drinking a bottle? ☐ Yes ☐ No

Does your child take a bottle to bed? ☐ Yes ☐ No

If yes, what is in the bottle?: _____

What type of water does your child drink? ☐ City water ☐ Well water ☐ Bottled water ☐ Filtered water

Does your child take fluoride supplements? ☐ Yes ☐ No

Is fluoride toothpaste used? ☐ Yes ☐ No

How many times a day does your child brush? _____When are the teeth brushed? _____

Does your child drink sugary drinks? Ex: Juices, Sodas, Sports Drinks, or Energy drinks. ☐ Yes ☐ No

Does your child have or have they experienced any of the following?:

Speech Difficulties ☐ Yes ☐ No

Physical, Mental, or Emotional Impairment ☐ Yes ☐ No

Problems with the eruption or shedding of teeth ☐ Yes ☐ No

Orthodontic Treatment ☐ Yes ☐ No

Suck his/her thumb, fingers, or pacifier ☐ Yes ☐ No

Injuries to the mouth, head, or teeth ☐ Yes ☐ No

Complications from Dental Extractions ☐ Yes ☐ No

Cold Sores/ Blisters/ Oral Lesions ☐ Yes ☐ No

Does your child snore? ☐ Yes ☐ No

Participate in active recreational Activities ☐ Yes ☐ No

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing the incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Parent or Legal Guardian: _____ Date:_____

Doctor Signature: _____ Date: _____

PATIENT REGISTRATION AND FINANCIAL AGREEMENT
AMY M ROBERTS DDS, PLLC

Legal Name (First)_____ (Middle)_____ (Last)_____
I prefer to be called_____ Birth date_____ Marital Status: M S W D
Home Address_____ _____ _____ _____
(Street) (City) (State) (Zip Code)
Home#_____ Work#_____ Ext._____ Cell#_____
Please confirm my appointments at 1) phone#_____ or 2) email address:_____

Legal Guardian if a minor_____Relationship_____
Home Address (If different)_____ _____ _____ _____
(Street) (City) (State) (Zip Code)
Home#_____ Work#_____ Ext._____ Cell#_____

Primary Dental Ins. Co. Name_____ Policy/Group#_____
Insurance Co. Address_____ _____ _____ _____
(Street) (City) (State) (Zip Code)
Insurance Co. Phone# _____ Employee Name_____
Employee's Full Address (If different from above) _____
Employee's: Birth date _____ Employee's Insurance ID # (possibly your SS#) _____
EMPLOYER'S Name and Full Address_____

Secondary Dental Ins. Co. Name _____ Policy/Group#_____
Insurance Co. Address_____ _____ _____ _____
(Street) (City) (State) (Zip Code)
Insurance CO. Phone# _____ Employee Name_____
Employee's Full Address (If different from above) _____
Employee's: Birth date _____ Employee's Insurance ID # (possibly your SS#)_____
EMPLOYER'S Name and Full Address_____

I do understand that ***payment for services is due in full at the time of treatment.*** A 5% cash savings will be applied when services are **paid in full** by check or cash **on the day of service**.

When insurance benefits are assigned to the dentist, the estimated insurance payment will be deducted from the amount due for today's services. Accurate insurance information must be provided if we are to file insurance claims in your behalf. We are not responsible for any delay in processing insurance claims. ***It is the patient's responsibility to follow-up on insurance payment delays*.** Finance charges of 1.5% monthly (18% annually) will be added to the outstanding balance starting ***60*** days after services are initiated.

- Emergency patients new to the office must pay in full for services with cash or credit card (Visa, MasterCard, Discover, or American Express) on the day of service. An insurance claim will be sent with benefits mailed directly to the insured.
- Patients of record may pay their portion with cash, check or credit card.
- Patients with ***Direct Reimbursement Dental Plans*** will be given a detailed receipt showing services provided and payment for services. The Dental Plan will then reimburse the patient.

Regrettably, we must occasionally deal with returned checks and delinquent accounts requiring collection agency intervention and/or legal action. Accounts that are turned over for collection will be assessed a 15% surcharge on the account balance. Accounts will be assessed all costs incurred in settlement or litigation, including process services, court costs and attorney's fees. A $45.00 service charge is assessed on all returned checks. A message may be left on our voice mail should the office be closed when you call. We regret this policy is necessary and appreciate your cooperation in notifying us when your reserved appointment time cannot be kept.

I have read, understand and accept the provisions described in this financial policy agreement. I authorize payment of insurance benefits directly to Dr. Amy M. Roberts.

_____ _____
SIGNATURE OF RESPONSIBLE PARTY **(DATE)**
(This must be the signature of the person responsible for the payment of the account)

303 DENTAL GROUP
AMY ROBERTS DDS, PLLC
GENERAL CONSENT

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly,and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1 . **Drug or chemical reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia).** Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like in any other pursuit in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you.

At the time of your treatment, we will ask you to sign a more detailed consent form that is specific to any treatment you receive, but we wanted you to be aware of these general risks to dental treatment.

I have read and understand the statement on this page:

_____ _____
Patient's signature Date

_____ _____
Parent's signature (if minor patient) Date

AUTHORIZATION TO RELEASE DENTAL INFORMATION

To: Release to: Amy Roberts, DDS

Phone: 300 Plaza Drive, Suite 102

Mailing Address: Highlands Ranch, CO 80129

Ph: 303-683-3332 Fax 303-683-7979

Email: office@303dentalgroup.com

****

I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes personal health information.

****

When possible please provide the following information in electronic form to the above email address.

____ Copy of dental films (BWX within 1 year; FMX/panoramic film with 5 years)

____ Periodontal charting ____ History of treatment rendered by dentist or staff

____ Other: _____

A copy of this Authorization or my signature thereon may be used with the same effectiveness as an original.

Patient's Printed Name_____ DOB _____

Minors' Printed Names_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

Patient's or Authorized Person's Signature _____

MISSED APPOINTMENT AGREEMENT

Dr. Roberts and her staff value your time and reserve your appointment time just for you. We ask when you reserve an appointment, that you make every effort to keep that commitment. We understand personal emergencies and inclement weather sometimes occur and we do take that into consideration prior to charging for a missed or late cancelled appointment.

We ask you to provide us with at least 48 hours notice if you find you are unable to keep your commitment to come to your reserved appointment. Failure to do so may result in a missed or late cancelled appointment fee of $70.

We regret this policy is necessary and appreciate your cooperation in notifying us when your reserved appointment time cannot be kept.

_____ _____

(Printed name of patient or patient's representative/guardian) Date

_____

(Signature of patient or patient's representative/guardian)

_____

(Relationship to patient)

303 Dental Group

Amy Roberts DDS PLLC

300 Plaza Drive #102
Highlands Ranch, CO 80129
(303) 683 - 3332
office@303dentalgroup.com
www.303dentalgroup.com

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.

- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care

- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Effective Date of this notice: 01-01-2021

Privacy Officer: Amy Roberts DDS PLLC 300 Plaza Dr #102 Highlands Ranch, CO 80129 (303) 683-3332

We never market or sell personal information

ACKNOWLEDGEMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES*

I have received a copy of this office's Notice of Privacy Practices.

_____ _____

Printed Name **Date**

_____ _____

Signature **Minor's Name if Applicable**

***You May Refuse to Sign This Acknowledgement**

* * *

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

___ Individual refused to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgment

___ Other:_____

_____