PROVO PEDIATRIC DENTAL
745 North 500 west
Provo, UT 84601
801-373-4200

PATIENT INFORMATION

Name of child:_____ Nickname:_____

○ Male / Female ○ Age_____ Birth date_____ Hobbies: _____

Home address _____
Street City State Zip

Person financially responsible _____ Home Phone_____

Cell phone _____ E-mail address _____

Whom may we thank for referring you ?_____

Name of nearest relative / friend not living with you _____ Phone #_____

PERSONAL INFORMATION

Father's / Guardian's Name_____

Address_____

_____

Employer_____Phone#_____

Soc. Sec. # _____ Birth date_____

Do you carry dental insurance for minor/child_____

Mother's / Guardian's Name _____

Address_____

_____

Employer_____ Phone#_____

Soc. Sec. # _____ Birth date_____

Do you carry dental insurance for minor/child_____

INSURANCE INFORMATION

Insurance Company _____Phone Number _____

Address _____

Group # _____ Policy # _____ Primary or Secondary _____

DENTAL HISTORY

Date of last visit to the dentist_____ For what service_____

Any mouth habits - thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle etc?_____

Any unhappy dental experience? _____ Any injuries to mouth or teeth ?_____

MEDICAL HISTORY

Minor / Child Physician _____ City / State _____ Phone _____

Is Minor / child under care of physician now ? _____ Medications _____

Receiving any medication or drugs ? _____

Ever been hospitalized ? _____

Is there excessive bleeding when cut ? _____ Allergies / reactions _____

Ever had surgery ? _____

Is your child high strung or generally nervous ? _____

HAS MINOR / CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING ? IF YES, PLEASE CHECK

A.I.D.S / H.I.V. ☐	Cancer ☐	Hearing Problems ☐	Mononucleosis ☐
Anemia ☐	Chicken Pox ☐	Heart Problems ☐	Mumps ☐
Asthma ☐	Convulsions ☐	Hepatitis ☐	Respiratory Disease ☐
Bladder Problems ☐	Diabetes ☐	Kidney Disease ☐	Rheumatic Fever ☐
Birth Defects ☐	Downs Syndrome ☐	Liver Disease ☐	Sinus Problems ☐
Blood Disorder ☐	Epilepsy ☐	Measles ☐	Thyroid Disease ☐
Brain Damage ☐	Fainting ☐	Mental Retardation ☐	Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact ?

Name _____ Relationship _____ Phone _____

AUTHORIZATION

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. Because your child is a minor, a signed permission is required from a parent or guardian before any dental services can begin. Authorization is hereby granted. Furthermore, by signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree that interest will accrue on all past-due amounts at the rate of 18%per annum (1.5% per month) until paid in full. In the event any amount(s) is/are referred to a third party dept collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collections fee of up to 40% of the principal amount(s) owing as allowed by Utah code Annotated, sec. 12-1-11. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

Our office has a broken appointment policy. We require at least 24 hour notice to cancel an appointment. A broken appointment fee will be assessed for missed appointments. If more than three appointments are missed, the office will no longer see the patient. I agree to this policy and I am willing and I understand that I will be responsible for all charges incurred because of the policy.

Signature of Parent / Guardian _____ date _____

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Consent for Behavior Management

Dental practitioners are encouraged to perform behavior management consistent with their educational training and behavior experience. Behavior Management methods in pediatric dentistry are directed towards goals of communication and education. The following are methods we use to provide the highest quality of pediatric dental care.

1. **Voice Control:** Voice control is a controlled alteration of voice volume, tone, or pace to influence and direct the patients behavior.

2. **Hand Over Mouth:** H.O.M. is a commonly accepted and effective behavior management method which has been documented in the dental literature for over 25 years. A hand is placed over only the mouth, and behavior expectations are calmly explained. The hand is removed and the positive behavior praised.

3. **Nitrous Oxide Oxygen:** "Laughing Gas" Nitrous Oxide reduces or eliminates anxiety, enhances communication, decreases pain and increases tolerance for longer appointments.

4. **Physical Restraint:** Partial or complete immobilization of the patient is sometimes necessary to protect the patient and dental staff from injury. Restraint can be performed by dentist, staff, or parent, with or without the aid of a restraining device.

5. **Conscious Sedation:** A minimally depressed level of consciousness that retains the patients ability to breath and respond appropriately to physical stimulation of verbal commands.

6. **General Anesthetic:** Controlled state of unconsciousness preformed by a anesthesiologist in a hospital or surgery center.

I have read this paper and the behavior management methods have been explained to me. I consent to their use for my child/children.

_____ _____

Parent or guardian Date

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Provo Pediatric Dental: Office Policies

Insurance:

Provo Pediatric Dental will bill your insurance as a courtesy to our patients. You are financially responsible for all services not covered by your insurance company. Some to these services include: nitrous oxide (laughing gas), behavior management fee (conscious sedation appointment), composite facings, disking, pontics, lab fees, cosmetic bleaching . Please be aware that in addition to these procedures there may be other procedures that are not covered by certain insurances companies. It is your responsibly to know your own benefits. By signing the line below, you allow Provo Pediatric Dental to release all information necessary to secure payment of benefits and also authorize the use of your signature on all insurance submissions, whether manual or electronic.

Professional services are rendered to the patient, and not to the insurance company: thus, the insurance company is responsible to the patient and the patient is responsible to the doctor. We can't render service on the assumption that the charges will be paid for by the insurance company.

We require a minimum payment of 20% for all procedures the day of service. All remaining balance are due 90 days from the date of service. There is a $3.00 resubmit fee for any claims that are billed to the wrong insurance company.

Self Pay (No Insurance):

For our patients who do not have insurance, please be aware that we require payment of 50% for all procedures on the day of service. And that all remaining balances are due 90 days from the date of service. We also offer a 10% discount for that days services over $100, if you pay your balance in full on the day of service.

Medicaid:

You must have your Medicaid card with you at each appointment, otherwise we will need to reschedule your appointment. All services not covered by Medicaid must be paid at the time of service, unless otherwise directed. Some benefits not covered by Medicaid are: nitrous oxide (laughing gas), behavior management fee (conscious sedation appointment), composite facings, disking, lab fees, cosmetic bleaching, indirect pulp caps, perio-scaling, sealants on baby teeth, frenulectomys , misc. checks, pontics, and all orthodontic appliances. We accept Medicaid on new patients 4 and under, and will continue to treat them until age 4. After age 5 they may continue to be treating by our doctors, but we will not accept Medicaid.

Intra-Office Policies:

We ask that you only bring the patient(s) that are scheduled to see the doctor. We would be happy to schedule your appointments when it is easiest for you to have a sitter for your other children.

Our telephones are for office use only. If you have an emergency, we ask that you limit your calls to two(2) minutes. Due to the time that we allot to each appointment, please reschedule if you are 15 minutes late.

We have also noticed a lot of food being brought into our office. It tends to get smashed into the floor and get into the cushions of the couch and chairs. Please do not bring food into our office. Please also help keep our waiting room clean by picking up the toys, books / magazines that your children use or play with.

After you have read this entire document please sign below stating that you agree to abide by it.

_____

Signature Date

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Notice of Privacy Practices

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

Provo Pediatric Dental Privacy Practices

Provo Pediatric Dental understands that your medical/dental and health information is personal. Protecting your health information is important. We follow strict federal and state laws the require us to maintain the confidentiality of your health information.

Our organization

Provo Pediatric Dental has a open operatory atmosphere. You might hear and see what is going on in the next chair or in the next room. We find that this atmosphere work well. We do offer a private room for any one that would like to discuss treatment of their child in semi-private.

How we use your health information

When you receive care from Provo Pediatric Dental, we may use your child health/dental information for treating them and billing for services. Examples of how we use your information include:

Treatment-We keep records of the care and services provided to your child. Health care providers use these records to deliver quality care to meet child's needs.

Payment- We keep billing records that include payment information and documentation of the services provided to your child. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your child and to verify child on present plan or to notify them of upcoming services that may need prior notice or approval. For example, we may disclose information about services provided to your child to claim and obtain payment from your insurance company or medicaid.

Other services we provide

We may also use your health information to:

- Share information with third parties who assist us with treatment, payment, and health/dental care operations. Our business associates must follow our privacy practices.
- Reminder cards are sent out reminding parents that it is time for 6 month recalls for the child(optional, notify the scheduler if you do not wish to be reminded)

Sharing your health information

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situation are:

- To protect victims of abuse, neglect, or domestic violence
- When otherwise required by law
- When requested by law enforcement as required by law or court order

All other uses and discloses, not described in this notice, require your signed authorization. You may revoke your authorization at any time with a written statement.

Right to receive an accounting of disclosures

You may request an accounting of certain disclosure of health information made by us. Your request must state the period of time desired for the accounting, which must be within the six(6) years prior to the date of your request and exclude dates prior to April 14,2003. If you request an accounting more than once during a twelve(12) month period, we will charge a fee of $3.00 per request.

Our organization and affiliated providers may have different privacy practices from those described in this notice. If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we made about access to your child health information, we will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the office of civil right of the U.S. department of health and human services.

PRIVACY PRACTICES ACKNOWLEDGMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____

_Name Date