Smiles 4 Kids School Dental Program Patient Registration Form/Consent for Services

Teacher: ________________________ ☐ **Free and Reduced lunch?**

Patient's Name:___________________________________ Date of Birth:________________

Gender: M_____ F____

Parent/Guardian's Name: ___________________________ Date of Birth: _______________

Parent/Guardian's SS#: ________________________ (please circle one) married single widowed

Is this your first getting services through Smiles 4 Kids? Yes No

Do you have other children that are seen here? _________________________________

*Mailing Address:____

City:____________________________ State:________ Zip:________________

Home Phone#________________ **Cell #**__________________ **Best** contact: Home, Cell, Email, Text

Email Address: __________________________________

Insurance Information

CO Med /CHP+: State ID Number: _______________________________________

Primary Dental Insurance Company: _______________________________ __________

Group #________________________ Insurance Phone: _________________________

Subscriber Name: _________________________ Employer: ________________________

Date of Birth: ______________ SS #/Subscriber#_________________

Secondary Dental Insurance Company: ____

Insurance Phone: _________________________

Group #________________________ Relationship to Patient: _______________________

Subscriber Name: ___________________ Employer: _________________________________

Date of Birth: ______________ SS #/Subscriber#_________________

*Insurance is a contract between you and your insurance company. We will bill your insurance company as a courtesy to you. Although we estimate what your insurance company may pay, it is the insurance company that makes the final determination of your benefits. You must agree to pay any portion of the charges not covered by the insurance. I hereby authorize payment by my dental insurance company be directly made to Smiles 4 Kids, Inc. I also authorize release of any dental information necessary to process all dental claims. At the discretion of the office we may use the services of one or more credit reporting services. I acknowledge receipt of patient privacy practices (HIPAA). If not insured I agree to be responsible for payment of services rendered by Smiles 4 Kids, Inc. If account is turned over to collections, I understand a 10% annual interest will be added to my account.

____

Parent/Guardian Signature   Date

Dental History

Child's Name: _________________________ Date of Birth:___________________

Please Circle any of the following that your child has a history of:

Nursing/Bottle habits Pacifier

Thumb/Finger sucking Dental Grinding

Medical History

Is your child currently under a Doctor's care? _________ If yes, why? _____________________

____

Child's Physician's Name: ______________________________ Phone#____________________

Has your child ever been hospitalized or had a major operation? _________________________

If yes, please explain:____

Is your child taking any medications? __________________ What? ___________________________

____

Is your child allergic to any medications or substances? Circle all that apply!

Aspirin Penicillin Latex Dyes Foods Pollutants Metals/Acrylics

Others: ____

Has any member of the family, including your child, ever had a problem with general anesthesia?____

Are antibiotics necessary for dental work because of a **heart murmur, heart defect, artificial joint or other medical reason**? ________________________________

Does your child have any of the following? Please check all that apply!

__Aids/HIV
__Anemia
__Asthma
__Autism
__Birth Defects
__Bladder Conditions
__Blood Disease
__Blood Transfusions
__Bone/Joint Problems
__Brain Injury
__Bruising Easily
__Cancer
__Cerebral Palsy

__Chemotherapy
__Child Abuse
__Chronic Adenoid/ Tonsil Problems
__Cleft Lip/Palate
__Convulsions/Seizures
__Developmentally Delayed
__Diabetes
__Drug Addiction
__Emotional Disturbance
__Other: ___________

__Excessive Bleeding
__Fainting/Dizziness
__Fever Blisters
__Growth Problems
__Heart Surgery
__Headaches
__Hemophilia
__Hepatitis/ Liver Disease
__High Blood Pressure
__Kidney Disease
__Leukemia
__Mental Disability

__Orthopedic Problems
__Psychiatric Care
__Sickle Cell Anemia
__Tuberculosis
__Tumor/Growths
__Hyperactivity/ ADD/ADHD
___ Heart Murmur

Dr. Initials_____

If any of the above apply please explain:____

____

Parent/Guardian Signature: ______________________________________ Date:_________________

SMILES 4 KIDS. INC

INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES

The following is provided so as to allow you to make informed personal decisions concerning your child's dental treatment after considering the risks, benefits, and alternatives. Please read this form carefully and ask about anything you do not understand.

It is very important that you appreciate that we adhere to what we call the Paige, Anna, Layton, and Keegan Technique. Briefly stated, they are our own children and all treatment decisions in this office are based on the philosophy that we treat our patients the same way we would want our own children treated.

Our priority is to provide the best possible care to every single patient. However, providing high quality care can sometimes be extremely difficult or impossible because of the lack of cooperation by a child. Some behaviors that can interfere with our professional care include but are not limited to: aggressiveness, hyperactivity, physical resistance (grabbing, kicking, screaming, etc.), refusing to open their mouth or keep their mouth open long enough to perform treatment. Our goal is to help our child patients master the dental experience. Some children may cry as part of an avoidance scheme. All efforts will be made to obtain cooperation from your child; there are several alternatives in patient management techniques. These techniques may and will only be used to help gain your child's cooperation and to help prevent the child from causing injury to him/herself or the dentist/staff. We combine the following recognized techniques individually for each child:

***TELL-SHOW-DO: The child is told what is to be done using simple words and then shown what is to be done on a model or finger. Then the procedure is done exactly as told. Praise is given to reinforce positive behavior. Children have less anxiety when they know what to expect.**

***POSITIVE REINFORCEMENT: This technique rewards the child who displays any desirable behavior. Rewards include praise, compliments, gentle hug, or a prize, etc.**

***VOICE CONTROL: The attention of a child exhibiting disruptive behavior is gained by changing the tone or the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the voice change.**

***MOUTH PROP: A device placed in the child's mouth to prevent accidental closing and/or injury and to allow jaw muscles to relax for ease of swallowing.**

***PAPOOSE BOARD: A safety device used to limit disruptive movement to prevent injury and to enable the dentist to provide the necessary treatment similar to a blanket.**

***CALMING CHILD BY DENTIST/ASSISTANTS: Holding the child's hands or controlling leg movements with the intention of preventing possible injury.**

I hereby authorize and direct the dentists and/or dental auxiliaries of their choice, to utilize behavior management techniques listed above on this form to assist in the provision of necessary dental treatment with the exception of: (if none, so state)

____

I hereby acknowledge that I have thoroughly read and understand the Informed Consent For Patient Management Techniques. I also have had the opportunity to speak with the staff about any questions or concerns related to my child's dental treatment. I further understand that I have the right to be provided with answers to any questions I have that may arise during my child's treatment.

______________________ / ______________________________ / ____________

PATIENT'S NAME **SIGNATURE OF PARENT/GUARDIAN** **DATE**

NOTICE OF PRIVACY PRACTICE AKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1998("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up among 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.
- We will keep a record of your child's dental services so that we can provide good ongoing care. We will share our records with the Colorado Department of Public Health and Environment to track the services we provide but will not share your name or your child's name.

I acknowledge that I have received 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 its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

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

Patient Name ______________________________

Relationship to Patient ______________________________

Signature ______________________________

Date ______________________________

****I give consent for my child to receive the following dental services Smiles 4 Kids:**

- ☐ Dental Exam
- ☐ Dental Cleaning
- ☐ Fluoride Varnish Treatment
- ☐ Oral Hygiene Education
- ☐ Sealant(s) as needed

Payment (please check one):

- ☐ Bill my insurance
- ☐ Self-Pay (payment due on day of appointment unless payment arrangements are made)

Self-Pay Fee's (NO INSURANCE)

***Please make checks out to Four Corners Smiles 4 Kids**

____ **$100.80 New Patient Dental Exam**

____ **$57.75 Established Patient Dental Exam**

____ **$78.75 Dental Cleaning Under 13 years**

____ **$102.90 Dental Cleaning 14 years and older**

____**$45.15 Fluoride**

____ **$63.00 Sealants (per tooth)**

Payment By: ☐ **Check** ☐ **Credit Card** ☐ **Cash**

Credit Card #: ______________________________________

CCV: ________ **Exp Date:** __________

Name (as it appears on card): ________________________________

Type of Card: ______________________________________

Signature: ____