Stapleton Children's Dentistry

PATIENT INFORMATION

Patient Name _____ Date of Birth_____ Gender_____

Address_____ City _____ State_____ Zip_____

Cell Phone_____ Home Phone_____

What is the #1 thing for you are looking for in a dental office for your child?_____

What school does your child attend?_____

What is your child's favorite sport, character or hobby?_____

How did you hear about us?_____ What is your favorite 90's Jam?_____

RESPONSIBLE PARTY INFORMATION

Parent #1 Name_____ Date of Birth_____ Legal Custody_____

Employer_____Occupation_____Phone_____

Social Security #_____ Drivers License #_____Date of Birth_____

Email Address_____ Relationship to Patient_____

Parent #2 Name_____ Date of Birth_____ Legal Custody_____

Employer_____Occupation_____Phone_____

Social Security #_____ Drivers License #_____Date of Birth_____

Email Address_____ Relationship to Patient_____

PATIENT MEDICAL HISTORY

Is this your child's 1st dental visit? YES NO
Pr evious Dentist_____
Is your child in good health? YES NO
Does your child have any mental or physical handicap? YES NO
If yes explain_____
Does your child have a thumb or pacifier habit? YES NO
Is your child taking any medication? YES NO
If yes what?_____
Does your child have any food allergies, latex, ect. YES NO
If yes what?_____
Is your child allergic to any medication? YES NO
If yes what?_____
Has your child ever been hospitalized? YES NO
If yes what for?_____
Does your child see a pediatrician regularly YES NO
Office Name_____
Dr's Name_____
Does your child have reoccurring strep throat/ ear infections? YES NO
If yes which?_____

Has your child ever had any of the following? If YES, Please explain below.		
	YES	NO
Development Delay/Autism		
ADHD		
Liver, Kidney or GI disease		
Diabetes		
Bleeding/Clotting disorder		
Epilepsy/Seizures		
Tuberculosis		
Hormonal Dysfunction		
Asthma		
Tumor/Cancer		
Heart Disease		
Mumps/Measles/Chicken Pox		
Birth Defects		
Pneumonia/Lung Disease		
AIDS or related complex		
Other/Explanations_____ _____		

AUTHORIZATION TO TREAT A MINOR

I_____ as the Parent/Guardian of _____, am legally able to make all medical/dental decisions for said child. I understand that by signing this form, all responsibility for consenting to proposed and performed treatment is my decision, and I do not legally need to consult anyone else in order to authorize treatment. I certify that I have read and understand the above information to the best of my knowledge.

_____ _____
PARENT/GUARDIAN SIGNATURE **DATE**

_____ _____
DR. FAIYAZ SIGNATURE **DATE**

Thank you for choosing us!

Stapleton Children's Dentistry

OFFICE POLICIES

Your appointment time is set aside especially for you. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we would appreciate a 48-hour notice.** Repeated cancellations or failures could result in a broken appointment charge or no reappointment.

We will be fair in working out special finances with you, but please also be fair to us with your commitments. ***A 1.5% finance charge will be assessed monthly on all overdue balances.***

ABOUT FINANCIAL ARRANGEMENTS AND DENTAL INSURANCE

We are committed to providing your child with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve this goal, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are provided. We accept cash, check, Visa, Mastercard and Care Credit. We will be happy to help you process your insurance claim for your reimbursement.

We will gladly discuss your child's proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Most insurance companies have a deductible that must be met before the company will pay their portion. If you have not met your deductible for the year, you are responsible for any charges until the deductible is met. Even after the deductible is met, most companies still only pay a percentage (such as 50% or 80%) up to the maximum yearly allowance and you will be responsible for the remainder.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

We must emphasize that as a dental care provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are provided.

If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us; we are here to help you.

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

CONSENT

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my health or change in my medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company. I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services provided. I have read and understand the above information.

_____ _____

PARENT'S SIGNATURE DATE

PRIVACY NOTICE

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

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 303-399-5437.
We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Stapleton Children's Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.
We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.
Stapleton Children's Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Stapleton Children's Dentistry.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Stapleton Children's Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I_____ have reviewed Stapleton Children's Dentistry's Privacy Policy.

Signed _____