Wild For A Smile

Pediatric Dentistry

Welcome to the office of Wild For A Smile. We welcome you and your children to our family. We are glad you chose our practice for your children's dental care. You have made a great choice!

Our immediate goal is to give your child 100% of our love and expertise at each visit. This will lead to our ultimate goal; to educate a generation of young people on how to achieve excellent oral health and to encourage life-long attitudes toward dental care.

We will always endeavor to explain every step at each visit to your children in carefully chosen non-threatening terms they will understand. You are always welcome to be with your children during their visits unless we feel your presence will be detrimental to our treatment goals for that day. We will always discuss this with you.

All of us place the highest possible value on the care we provide your children. We look forward to meeting you and your children, and to a long relationship working toward our mutual goals. To make all appointments as special as possible for your child, we ask no siblings accompany them.

Enclosed you will find a Medical & Dental History form, a financial policy and our consent form. Please fill these out and bring them with you to your first visit. Your full **estimated payment** is expected at this first visit. As a courtesy we will bill your insurance if all insurance information is furnished.

This appointment has been reserved for your child. Please give at least a 48 hour cancellation notice if you are unable to keep your appointment. By providing us with 48 hours notice we are able to open that scheduled time to patients that are in need of treatment and have been waiting to be seen.

Sincerely,

Wild for a Smile and Staff

1819 61st Avenue, Suite 101 1 • Greeley, CO 80634 • 970-506-1339 • Fax: 970-339-8500 • www.wildforasmile.com

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ABOUT YOUR CHILD

Child's Name (First) (MI) (Last)

M / F

Name child prefers to be called

Date of Birth Age School (if applicable)

Reason for Visit: _____

Child's Hobbies: _____

Names of other children: _____

Referred by: _____

DENTAL HISTORY

Is this your child's first dental visit? Y / N

Previous dentist City, St

Date and nature of last visit

Any history of injuries to your child's teeth or jaws? Y / N
When & how? _____

Child finished nursing or bottle-feeding at age: _____

Habits (circle):

Thumb/finger sucking	Now / In past
Pacifier	Now / In past
Teeth grinding or clenching	Now / In past
None	

What is the main source of drinking water in your home?
❒ City ❒ Well ❒ Filtered ❒ Other _____

Has your child experienced any unfavorable reaction to previous medical or dental care? Y / N (If yes please explain)

How do you think your child will respond to dental treatment?

MEDICAL HISTORY

Physician's Name Phone #

Emergency contact name Relationship

Address City/State Phone #

Is your child currently under the care of a physician for a specific medical problem? Yes No
If yes, what? _____

Is your child currently taking any prescription or over-the-counter medications? Yes No
If yes, what? _____

Has your child had a history of taking any medications frequently? Yes No
If yes, which ones? _____

Does your child take prescription fluoride? Yes No

Is your child allergic to any ***food*** or medications? Yes No
If yes, what? _____
What was the reaction? _____

Does your child have an allergy to latex, dyes, or metals? Yes No
If yes, what? _____
What was the reaction? _____

Has your child ever been hospitalized or had surgery? Yes No
For what? _____

Has any member of your family, including your child, had a problem with general anesthetic? Yes No
If yes, describe: _____

Are your child's immunizations up to date? Yes No

Have you ever been told that your child requires antibiotics prior to dental treatment because of heart defect or any other medical condition? Yes No

MEDICAL HISTORY (Continued)

Has your child been diagnosed as having any of the following conditions? (Please check yes or no for each):

Y	N		Y	N	
❑	❑	AIDS/HIV	❑	❑	Ear problems
❑	❑	Anemia	❑	❑	Excessive gagging
❑	❑	Arthritis	❑	❑	Fainting or dizziness
❑	❑	Asthma	❑	❑	Fever blisters
❑	❑	Autism	❑	❑	Growth Problems
❑	❑	Bladder conditions	❑	❑	Hearing impairment
❑	❑	Blood disease	❑	❑	Heart murmur / defect
❑	❑	Blood transfusions	❑	❑	Heart surgery
❑	❑	Birth defects	❑	❑	Hemophilia
❑	❑	Bone or joint problems	❑	❑	Hepatitis
❑	❑	Brain injury	❑	❑	High blood pressure
❑	❑	Bruises easily	❑	❑	Hyperactivity / ADHD
❑	❑	Cancer or malignancies	❑	❑	Kidney disease
❑	❑	Cerebral palsy	❑	❑	Liver disease
❑	❑	Chemotherapy or radiation	❑	❑	Neurological problems
❑	❑	Child abuse	❑	❑	Nutritional deficiency
❑	❑	Chronic infections	❑	❑	Pain in jaw joints
❑	❑	Chronic headaches	❑	❑	Premature birth
❑	❑	Cleft lip / palate	❑	❑	Psychiatric care
❑	❑	Congenital heart disease	❑	❑	Respiratory disease
❑	❑	Convulsions or seizures	❑	❑	Rheumatic fever
❑	❑	Developmental delay	❑	❑	Sickle cell disease
❑	❑	Diabetes	❑	❑	Speech disorder
❑	❑	Drug addiction	❑	❑	Syndrome: _____
❑	❑	Emotional disturbances			_____
❑	❑	Epilepsy	❑	❑	Other: _____
					_____

❑ ❑ Do you wish to speak with the doctor privately about any special concern (medical concerns or otherwise)?

INSURANCE

Primary Dental Insurance Company — Group #

Address — Phone

Policy holder's name — Relationship to patient

Secondary Dental Insurance Company — Group #

Address — Phone

Policy holder's name — Relationship to patient

Medical Insurance Company — Group #

Address — Phone

Subscriber's Insurance I.D. #

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT

Mother's full name — DL #

Address

City — State — Zip

Social Security # — Date of birth

Home Phone — Business Phone — Cell Phone

Email Address

Employer — Occupation

Father's full name — DL #

Address

City — State — Zip

Social Security # — Date of birth

Home Phone — Business Phone — Cell Phone

Email Address

Employer — Occupation

Child lives with: ❑ Both Parents ❑ Mother ❑ Father ❑ Other

Contact Preference: ❑ Phone Call ❑ Email ❑ Text

AUTHORIZATION

I understand that I am responsible for all charges incurred by me or my family and that my estimated payment is due at the time of service. I hereby authorize payment directly to Dr. Doll from insurance companies listed above. I agree to payment of any co-pays, deductibles, and uncovered services or amounts. I authorize the release of any information necessary to process insurance claims. If my account requires servicing for collection, I understand that I will be liable for fees and 18% interest in addition to my outstanding balance.

Signature — Date

CONSENT

I give the doctor permission to use such measures as deemed necessary in her professional judgment to render diagnosis and treatment for my child. This includes an oral examination, radiographs and other diagnostic aids. I have given an accurate report of my child's dental and medical histories.

Signature — Date

Relationship to Child

REVIEWING DOCTOR'S SIGNATURE — DATE

GUIDELINES FOR PARENTS

Dear Parents:

You may choose whether or not you would like to accompany your child to the treatment area for his/her appointment. Although we sense that many times children do better without parents present, you are welcome to be present while your child is having their dental care at all times.

We ask that siblings remain in the reception area for the duration of the appointment.

If you choose to be present, we suggest the following guidelines to ensure the most positive outcome:

1. **Allow us to prepare your child.**
2. **Be supportive of the practice's terminology.**
   - ●We don't use "needles" or "shots"; we use "sleepy juice so your tooth gets sleepy."
   - ●We don't "drill" teeth; we "clean or chase the sugar bugs out" of them.
   - ●We don't "pull" or "yank" teeth; we "wiggle" them.
3. **Please be a silent observer.**
   - ●This allows us to maintain communication with your child.
   - ●3-way communication is ineffective and confusing for your child as you may give incorrect or misleading information.
4. **Your child's behavior.**
   - ● "Acting out" is normal when a child is nervous, but may inhibit our ability to complete the work scheduled for the visit.
   - ●Many children will try to control the situation by acting out.
   - ●We will **not use any restraints** to treat your child.
   - ●We will continue to support your child at all times.

Knowing these guidelines in advance can help you better support your child and will allow for a positive experience. We are confident that all will go well and hope that these guidelines will help prepare you with confidence for the upcoming appointment.

Sincerely,

Wild For A Smile and Staff

Wild For A Smile

CONSENT

Because your child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental treatment can be started by Dr. Mischelle or her staff. Our examinations may include dental radiographs ("x-rays") depending on your child's specific needs. Photographs for diagnosis/ treatment planning and teaching purposes may be taken.

Consent is herby given for diagnostic, restorative and surgical treatment for my child. Restorative treatment may include fillings, crowns, nerve treatment, or space maintainers. Restorative materials may include tooth colored bonded fillings or crowns, nickel-chromium "steel" crowns, or bonded sealants. Surgical treatment may include tooth removal, minor gum or soft tissue surgery.

Local anesthesia and nitrous oxide/oxygen analgesia ("laughing gas") are used routinely to facilitate your child's comfort during treatment.

Your child's specific treatment needs will be explained to you after the examination and prior to any treatment. We will also review with you the treatment that was performed after each visit.

Should it become necessary to sedate your child because of behavior, you will be consulted. Physical restraint is not used without parental consent unless it becomes necessary to protect your child from self-injury. In any such case, we will ask you to assist us, as we do not use physical restraints in our office.

Since we make the ***safety*** of our patients being treated our number one goal, ***we do not allow siblings to be present in the room while patients are being seen***. ***We ask that all siblings remain in the waiting room at all times***. We apologize for any inconvenience this may cause.

I have read this consent for treatment and I understand the contents. In addition, I acknowledge that I will be responsible for arranging for payment of any bills incurred during my child's dental treatment.

_____ _____

Patient Name Parent or Guardian

Wild For A Smile

PARENT-DENTIST COMMITMENT
FINANCIAL POLICY

We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Your **estimated payment** is due at the time of service. Payment is due at the time service is provided. Our office accepts cash, Visa & MasterCard. Outside financing is available through a Dental Financing Plan upon request and approval.

Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

If you have any questions regarding our financial policy, please ask. We are committed to providing you with the most positive experience in dental care.

Our Cancellation Policy is:
To bring the highest level of service to our entire patient population. In order to do this we maintain a strict respect for your time and strive to see all of our patients at their appointed times. We know you respect this and strive for the same. At times we have a "waiting list" of patients wanting earlier appointments than we are able to provide. Subsequently, we request 48 hours of notice if you need to change your appointment for any reason. Cancellations provided with less than 48 hours notice may result in a pre-payment by you to schedule the next appointment. This enables us to accommodate as many needs as possible by offering the cancelled appointment to others.

I have read the above internal policies and understand my **financial options** and obligation as well as the **cancellation policy** as described.

_____ _____
Parent/Responsible Party Signature Date

_____
SSN# of Parent/Responsible Party

Wild For A Smile

ASSIGNMENT OF BENEFITS AGREEMENT

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand that the contract regarding your dental benefits is between you, your employer, and your insurance company. ***The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company.*** The following provisions identify our policies governing insurance claims.

- Although we are willing to submit your child's claim on your behalf, **we do not accept responsibility** for the outcome of the transaction**. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement.** By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your child's treatment.
  Initial _____

- We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

- **We require you to pay a percentage of treatment at the time of service. Any overpayment will be reimbursed to you upon receipt of payment from your insurance carrier. If there is a balance due, we will bill you at that time**.

  Initial _____

- Insurance payments ordinarily are received within 30-60 days from the time of billing**. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time.** You will be responsible for seeking reimbursement from your insurance company. **Initial** _____

- Our office **does not guarantee** that your insurance company will pay for treatment your child receives from our practice. If you are unsure of your dental insurance coverage, please contact your insurance carrier for more information. If your claim is denied, you will be responsible for paying the full amount at that time. **Initial** _____

- Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE DOCTOR.

_____	_____	_____
Patient's Name	Signature of Parent/Responsible Party	Date

_____	_____	_____
Subscriber's Name	SSN#	DOB

Wild For A Smile

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect (01/01/04), and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change the Notice and make the new Notice available upon request.

You many request a copy of our Notice an any time. For more information about our privacy practices, or for additional copies of the Notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locations) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our profession judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up fill prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: WE may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safely or the health of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Contact us using the information listed at the end of this Notice for full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14th, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency.)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations (You must make your request in writing.) Your request must specify the alternative means or location, and proved satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web Site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Wild For A Smile

Telephone: (970) 506-1339 Fax: (970) 339-8500

Address: 1819 61st Ave Ste 101

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (November 28, 2017)

Wild For A Smile

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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

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

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

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 acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify)

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