Children's Crossing Pediatric Dentistry
76 E Commerce Drive Suite 100
Saratoga Springs, UT 84045 Date:_____________

Patient Information

Name: ____ Preferred Name: ________________ Male / Female

Date of Birth: __________________ Age: _____ Height: ______ Weight: _____ Phone #: __________________

Address: _______________________________________ City: ___________________ State: ______ Zip: ________

Whom may we thank for referring you to our office? ____

Parent's Marital Status: _____ Married ______ Single ______ Divorced ______Widowed

Tell us about your Child's Dental History

Why did you bring your child to the dentist today?____

Is this your child's first dental visit? Yes No Name of previous dentist: ____________________ Last visit date______

How do you think your child will behave today? (Check all that may apply)

___ friendly ___ happy ___ anxious ___ timid ___ afraid ___ resistant ___ combative

Has your child ever has a serious/difficult problem associated with previous dental work? Yes No

Is your child's water fluoridated? Yes No Is your child taking fluoride supplements? Yes No

Does your child brush his/her teeth daily? Yes No Floss daily? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Are you happy with the appearance of your child's teeth? Yes No Explain if no ____________________________

Does your child have any of the following habits?

Y N Lip Sucking/Biting Y N Nail Biting Y N Nursing/Bottle Habits Y N Thumb/Finger Sucking

Tell us about your Child's Medical History

Has your child had a history or difficulty with any of the following? If yes to any, please describe below.

Y N Abnormal Bleeding
Y N Any Blood Disease or Anemia
Y N Allergies to any drugs (list below)
Y N Asthma
Y N Brain Injury
Y N Cancer or Malignancies
Y N Cerebral Palsy
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Eye, Ear, Nose, Throat Problems
Y N Gag Reflex
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV/AIDS
Y N Kidney/Liver Problems
Y N Mental or Learning Delay
Y N Other Heart Ailment
Y N Premature Birth
Y N Rheumatic Fever
Y N Speech Disorder
Y N Tuberculosis (TB)
Y N Tumors or Growths
Other, explain below

If Heart Condition present, does your child require an antibiotic premed prior to having certain procedures done? Yes / No

Name of child's physician ____ Phone #: __________________________

Is your child under doctor's care now? Yes No For what reason?____

Please list all drugs or medications your child is currently taking: ____

Has your child had any serious medical problems? ____

Has your child ever been hospitalized and/or had operations? Yes No Reason: ______________________________

Please list all drugs your child is allergic to: ____

If you answered yes to any questions above, please give any additional information necessary. ______________

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Parent/Guardian Information

Mother (full name) ______________________________

Check if you are Mother ____ Step Mother ____ Legal Guardian ____ Other ______________

Address ______________________ City ____________ State _____ Zip ________

Hm phone: ______________ Wk phone: ______________X ______ Cell: ______________

SS #: ______________ Drivers License St & # ______________ Date of Birth ____________

E-mail: ______________________ Employer: ______________________

Father (full name) ______________________________

Check if you are Father ____ Step Father ____ Legal Guardian ____ Other ______________

Address ______________________ City ____________ State _____ Zip ________

Hm phone: ______________ Wk phone: ______________X ______ Cell: ______________

SS #: ______________ Drivers License St & # ______________ Date of Birth ____________

E-mail: ______________________ Employer: ______________________

Nearest relative not living with you. Name ______________________ Phone #: ______________

Relationship to patient ______________________

Primary Dental Insurance Information	**Secondary Dental Insurance Information**
Insurance Company ______________	Insurance Company ______________
Address ______________	Address ______________
______________	______________
Phone: ______________	Phone: ______________
Group #: ______________	Group #: ______________
Subscriber's Name: ______________	Subscriber's Name: ______________
Subscriber's ID #: ______________	Subscriber's ID #: ______________
Subscriber's Date of Birth: ______________	Subscriber's Date of Birth: ______________
Employer: ______________	Employer: ______________
	* Please be aware, secondary insurance may not cover the balance of charges after your primary insurance pays. You may have a portion to pay for treatment.

PLEASE NOTE: Your insurance is billed as a courtesy; you are responsible for your child's account

I understand that the information that I have given is correct to the best of my knowledge, 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.

I authorize the Children's Crossing Pediatric Dentistry and associates to perform the necessary dental services my child may need.

______________________________________ ______________

Signature of Parent or Legal Guardian Date

Children's Crossing Pediatric Dentistry
76 E Commerce Drive Suite 100
Saratoga Springs, UT 84045
801-766-4900

Financial Agreement

Our primary goal is to provide the highest quality dental care to infants, children and adolescents. Payment for treatment is expected at the time of service. We offer the following payment options:

1. We accept cash or check
2. We accept AMEX, VISA, MasterCard and Discover Card
3. We also accept Care Credit (please ask for details)

For our families who do not have dental insurance, we do offer a cash discount of 20% when you pay your account in full on the day of service. Please ask if other arrangements are necessary.

If a patient has dental insurance, the responsible party will pay the patient estimated portion and/or deductible on the day of service. The insurance will be billed as a courtesy; however, please be aware, **if the insurance company does not pay within 60 days, payment in full is expected from the responsible party. It is the parent's responsibility to know and understand their insurance benefits.** Fees quoted in our office are estimates only. Please understand that insurance companies pay benefits based on their own fee schedule. It is impossible for us to know every insurance fee schedule and their limitations. We are always happy to submit a pre-authorization per your request if you are unsure of your coverage and limitations.

Some procedures are not covered by all insurance companies. The parent is responsible for anything their insurance does not cover. In our office, we use a white filling material. Please be advised that some insurance companies will reduce their benefit to a silver filling rate. **The responsible party must pay the difference, if any, between the two rates.**

Every 6 months children will receive a full exam, necessary x-rays, cleaning and fluoride treatment. If the patient's insurance does not cover any of these services **every 6 months**, it is the parent's responsibility to let us know before we take the child back for their appointment. Be aware that patients referred from another office may have to pay for the examination and x-rays, as limited by the patient's insurance plan.

In accordance with the Federal Truth-In-Lending Act, please be advised that interest will be charged at the rate of 18% annually on past due balances. If this account is sent to collections, we agree that in addition to any amount left owing to Children's Crossing Pediatric Dentistry, we will be responsible for interest at the rate of 18% annually on any past due balance, calculated from the date of service, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee.

I hereby authorize Children's Crossing Pediatric Dentistry and all associates to release any and all medical and/or dental information to the insurance carrier. I hereby authorize payment directly to Children's Crossing Pediatric Dentistry and all associate's insurance benefits otherwise payable to me. I understand that I am financially responsible for any and all charges not covered by this authorization.

I have read and understand the above policies and accept the terms of this agreement.

Signature of authorized person: ____ Date: __________

Relationship to patient/s: ____

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

This notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past or future physical mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your dentist, our staff and others outside of our office that are involved in your case and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

Payment: Your protected information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of you dentist's practice. These activities include, but are not limited to quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker's Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights
Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information Under federal law, however, you may not inspect or copy the following records, psychotherapy notes; information complied in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right the request to receive confidential communications from us by alternative means or at an alternative location.
You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your dentist amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right t object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 14, 2010.

We are required by law to maintain the privacy, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name________________________ Signature________________________ Date____________