Welcome

Patient ID #_____ Today's Date _____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Phone _____

Responsible Party

Name _____

Relationship _____

Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Email _____

SS#/SIN _____

DL # _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Best time to call _____

Time _____ Days _____

_____

Mother ☐ Stepmother ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____

Amount already used _____

Max. annual benefit _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check

Credit Card ☐ Visa ☐ MC ☐ I wish to discuss the office's payment policy.

Dental & Health History *CONFIDENTIAL* Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush?_____ How often does your child floss?_____
Is your child's water fluoridated?..... ☐Yes ☐No Does your child take fluoride supplements?..... ☐Yes ☐No
Does your child:
Suck thumb/finger ..... ☐Yes ☐No Chew hard objects (pencils, etc.) ..... ☐Yes ☐No
Suck/Bite lip ..... ☐Yes ☐No Grind teeth ..... ☐Yes ☐No
Bite/Chew nails?..... ☐Yes ☐No Clench jaws ..... ☐Yes ☐No
Previous dentist _____ Address _____
Date of last dental visit?_____ _____
Has your child had difficulty with previous dental visits? ☐Yes ☐No
Child's physician_____ Address _____
Phone #_____ _____
Previous Hospitalizations/Surgeries/Serious Illnesses? When?
_____ _____
_____ _____
Is your child currently taking medications? ☐Yes ☐No (if yes, please list)
Has your child ever taken Fen-Phen/Redux? ☐Yes ☐No
Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐Yes ☐No (if yes, please describe) _____
Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

Has your child ever had any of the following:
Asthma ..... ☐Yes ☐No Stomach, liver or kidney problems ..... ☐Yes ☐No
Cancer ..... ☐Yes ☐No Handicaps/Disabilities..... ☐Yes ☐No
Hepatitis..... ☐Yes ☐No Tuberculosis ..... ☐Yes ☐No
HIV/AIDS ..... ☐Yes ☐No Diabetes..... ☐Yes ☐No
Hemophilia ..... ☐Yes ☐No Rheumatic Fever ..... ☐Yes ☐No
A persistent cough or throat clearing Congenital Heart Defect ..... ☐Yes ☐No
not associated with a known illness Heart Murmur ..... ☐Yes ☐No
(lasting more than 3 weeks)..... ☐Yes ☐No Convulsions/Epilepsy ..... ☐Yes ☐No
Abnormal Bleeding ..... ☐Yes ☐No

Please explain any medical problems that your child has: _____

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____
Signature of patient (or parent/guardian if minor) Date
Dentist Review:

_____ _____
Signature of Dentist Date

LAFAYETTE DENTAL EXCELLENCE
511 Crossing Drive
Suite 200
Lafayette, CO. 80026
303-664-1001

POLICIES

The undersigned patient has sought and /or obtained professional treatment and services from Lafayette Dental Excellence whose address is 511 Crossing Drive, Ste 200, Lafayette, CO., 80026.

The patient understands and by his/her signature below agrees that the charges for professional services provided by Dr. Mitchell Friedman, D.D.S., Andrew Holecek, D.D.S., or any employee are due and payable in full upon those services being rendered.

Although you are responsible for the entire balance at the time of service, it is our office policy to bill your insurance carrier as a courtesy to you. We do require that your estimated share and / or co-payment be made at the time of service. If your insurance does not remit payment within 45 days, the entire balance will be due in full from you. We do not submit or collect from secondary insurance but will provide you with a claim to send to them for reimbursement.

The patient understands that a 24-hour notification to cancel is required otherwise an $90.00 cancellation fee per hour may be charged to his/her account. Monday appointments must be canceled no later than 1:00 P.M. the Friday before.

Our fees are registered as usual and customary with the Denver area. Some insurance companies set their own usual and customary fees, which may not be the same as our fees. The patient understands that any difference not paid by insurance will be the responsibility of the patient. It is the patient's responsibility to be aware of their insurance company's benefits.

The patient further understands and agrees that if the balance due is not paid in full within 60 days from the date of service, there will be a billing charge of $5.00 per month as well as a 1.75% per month late payment charge until the outstanding balance is paid in full. There will be a $30.00 service charge on all returned checks.

If the account is assigned to our collection agency, the patient will be responsible for the entire account balanced owed plus any collection and legal fees accrued.

Patient (or Guardian) Signature_____Date_____

Witness_____

Lafayette Dental Offi
511 Crossing Drive, Suite 200
Lafayette, Colorado 80026

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 INFORMATION 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 2/1/12, 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 this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this 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 locating) 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 professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled 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 safety or the health or safety of others.

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 Your 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**
- ☐ **communication barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**

Lafayette Dental Excellence
511 Crossing Drive
Suite 200
Lafayette, CO. 80026

Lafayette Dental Excellence

Address: 511 Crossing Drive, Suite 200 Lafayette, CO 80026
Phone: (303) 664-1001 • Email: smile@lafayettedentalexcellence.com • Web: http://

We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request Appointments Online
- Confirm Appointments via Email
- Receive Text Message Appointment Reminders
- Submit Patient Satisfaction Surveys
- Refer Your Friends Online

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email or by replying to a text message with 'STOP'. Standard Text Messaging rates apply.

Please Verify Your Contact Information

	Current Information on File:	Corrections, if any:
Name:		
Address1:		
Address2:		
City:		
State:		
Zip:		
Home Phone:		
Work Phone:		
* Cell Phone:		
		___ Check here to Opt In to Text Messages
* Email:		
		___ Check here to Opt In to Email

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for Lafayette Dental Excellence in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Lafayette Dental Excellence in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any e-mail or other communications without user permission, and do not send spam.

Please sign below that you agree to allow us to use this information in providing your services.

_____ _____

Signature Date

Date: September 2, 2010 11:36