Children's Hospital Colorado

CHILDREN'S HOSPITAL COLORADO DENTAL CENTER

Patient Name: _____ Date of Birth: _____

Social Security Number: _____Medicaid Number: _____

PARENT/LEGAL GUARDIAN INFORMATION

Mother's Name: _____ Date of Birth: _____

Social Security Number: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

Father's Name: _____ Date of Birth: _____

Social Security Number: _____ Email Address: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (____)_____ Work Phone: (____)_____ Cell Phone: (____)_____

INSURANCE INFORMATION

Primary Dental Insurance: _____ Group or Plan Number_____

Insurance Company Address: _____

Subscriber's Name (Person that holds the insurance plan): _____

Social Security Number of Insured: _____ Relationship to Patient: _____

Employer: _____

Secondary Dental Insurance: _____ Group or Plan Number: _____

Insurance Company Address: _____

Subscriber's Name (Person that holds the insurance plan): _____

Social Security Number of Insured: _____ Relationship to Patient: _____

Employer: _____

REFERRING DENTIST/PHYSICIAN INFORMATION

Doctor Name_____ Telephone Number_____

Address: _____ City: _____ State: _____ Zip: _____

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In case someone other than you (the parent/legal guardian) accompanies your child to future dental appointments, may this person (if over 21 years) give consent by proxy to possible treatment plan changes? For example: the patient's sister or aunt brings the child to the appointment and a tooth that was planned to receive a silver filling needs a crown instead.

May this person decide this change for you? ☐ YES ☐ NO If NO, what should we do?

☐ Reschedule. A parent will come with the patient to the next appointment.
☐ Call (_____)_____ to discuss the change with a parent.
If nobody can be reached, we will reschedule.

Do you give us permission to leave appointment information on your answering machine? ☐ YES ☐ NO

Pediatric Dental Clinic Policies

Children's Hospital Colorado Dental Center operates training programs that include teaching and training of pediatric dentistry residents as well as pre-doctoral dental students.

We have established the following rules to help us to accomplish our mission and ensure quality patient care for all children. Our goal is to provide affordable quality oral health care in an efficient manner to children, adolescents, and individuals with special needs. We sincerely appreciate your assistance with the following:

1. Please bring your insurance card (i.e. Medicaid card) or other valid billing information to each visit. Without such information we will mark the account as self-pay.
2. Self-pay patients must pay full amount at time of service. If you are unable to make such payments, arrangements for payment must be set-up with the dental billing department or financial counseling must be arranged at the hospital.
3. For all appointments, *we require an early check-in prior to the appointment* to ensure completion of all required paperwork as follows:
    a. Recall – 15 minutes.
    b. Operative – 15 minutes
    c. New Patient Evaluations – 30 minutes. If you have completed new patient paperwork prior to the appointment, we ask that you arrive 15 minutes prior to the appointment.
4. If you are up to 15 minutes late for your scheduled appointment, we will try to work you in as the schedule allows. If you are more than 15 minutes late, we cannot guarantee that we can see your child and may need to reschedule.
5. Except for true emergencies (i.e. trauma, swelling, bleeding, infection) we see patients at their scheduled appointments.
6. Due to our long wait list for children to be seen at our clinic, we request at least 24 hour notice if the appointment cannot be made.
7. All reminder calls for scheduled appointments are made two days prior to the appointment. Please ensure that we have all current telephone numbers at each visit. If you have not received a call please call us to confirm. If we are unable to confirm your child's appointment we may not be able to hold the appointment time.
8. If three appointments are missed without adequate notice, we will refer you to another clinic. Please note, for new patient evaluations, two missed appointments will not be rescheduled.

Please indicate your agreement to these policies by signing below.

Date: _____ Signature _____

Medical and Dental History Form

Please complete the following form so we may better serve your child

Child's name: _____ **Date of birth:** _____ **Gender:** □ Female □ Male

What is the main reason for today's dental visit? _____

Is your child currently ill? □ **Yes** □ **No** **If yes, please explain:** _____

Does your child have any allergies? □ **Yes** □ **No** **If yes, please explain:** _____

Does your child take currently any medications? □ **Yes** □ **No** **Please list below all including over-the-counter medicines and vitamins**

_____

Has your child ever had any of the following?	Yes	No	Comments
ADHD			
Asthma (Mild/Moderate/Severe/exercise induced)			
Autism			
Blood Disorders (eg. Anemia, Hemophilia, sickle cell disease)			
Cancer			
Cystic Fibrosis or Respiratory Disease			
Endocrine Disease (eg. Diabetes, Thyroid, Glandular)			
Genetic Disorder/Syndrome (please state)			
Heart Disease (eg., murmur, surgery, previous endocarditis, congenital abnormality)			
Immunocompromise			
Kidney Disease			
Liver Disease (eg. Hepatitis)			
Mental or emotional problems, or developmental delays			
Neurological Disease (eg. CP, seizures, TBI)			
STD or HIV			
Severe Headaches			
Sight, hearing or speech disorder			
Skin, bone, muscle, or joint disease			
Has the patient ever been to the hospital due to serious illness, injury, or surgery?			
Is your child MRSA positive?			
Was your child born prematurely or had complications during birth?			

Who is your child's Primary Physician or Physician's Group?

Name _____ in _____ Phone _____

Has the patient been seen in any other specialty clinics? Dose your child have any other condition that you did not mention above?

□ No □ Yes Please explain: _____

	Yes	No	Comments
Have you been referred to us?			
Previous dental experience?			
Injury to the face or teeth?			
Previous orthodontic treatment?			
Does child get help or supervision with brushing?			
Does your water have fluoride?			
Other sources of fluoride?			
Does the patient have any oral habits?			

I have personally reviewed this information with the parent and entered the data into axiUm.

_____ Parent/Guardian signature

_____ Date

_____ Resident DDS, DMD

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Children's Hospital Colorado Dental Center
Financial Policy

Fees and Payment Policy

In an effort to hold the line on dental costs while maintaining a superior level of professional care we have established the following payment options:

1. Payment in full or payment of estimated portion the insurance carrier will not cover; on the day treatment is rendered.
2. Payment of balance in full upon receipt of initial statement.
3. Payment plans are available upon request; you will need to contact one of our billing counselors at 720-777-6788 in order to make necessary financial arrangements.

Oral Hygiene Instructions

The basis for maintaining healthy teeth is practicing good oral hygiene on a daily basis. We consider it our duty to provide you with detailed instruction about the process how cavities form because this knowledge empowers you to avoid them in the future. Therefore, on every patient with plaque, we will make it visible with a dye. We will teach you good oral hygiene techniques and discuss a home care plan with you along with a review of proper diet and nutrition. The charge for this procedure (CDT code D1330) is $22.50. We will bill you or your insurance for this procedure.

Self-Pay or Non-Insured Patients

If you do not carry dental insurance you will receive a 35% discount on all services performed by our office.
We require an $80 down payment prior to your first visit, and you will be billed the remaining amount.
If you choose to pay for the remainder of your visit on the day treatment is rendered then you will receive an additional 5% discount for payment in full.

Insurance

If you have insurance we will help you determine the coverage you have available. Coverage varies from carrier to carrier. It is your responsibility to understand your dental insurance's coverage and limitations. It is important to understand that professional care is provided for you and not to an insurance company. In consequence, the insurance company is responsible to the patient, and the patient is responsible to our office for any balance not paid by the insurance. We are well versed in filing patient's claims and handling questions. We will help you in any way we can.

I understand the above statements regarding Children's Hospital Colorado Dental Center Financial Policy.

Child's Name _____

Parent/Guardian Name Printed _____

Signature _____ Date _____