Cedar View Pediatric Dentistry

Childs Name: First: _____ Last: _____ Male/ Female
Birth date: _____ Age:_____ Child lives with (circle): Mom Dad Both Guardian
Mailing Address: _____ City: _____ State: _____
Email address: _____ Zip code: _____

Mother: _____ Home Phone: _____ Cell: _____
SSN: _____ Birth date: _____ Employer: _____
Work phone: _____ Address if different than child's:_____

Father: _____ Home Phone: _____ Cell: _____
SSN: _____ Birth date: _____Employer: _____
Work phone: _____ Address if different than child's:_____
Name of Legal Guardian: _____ Phone: _____

Emergency Contact: _____ Phone: _____
(Not living in the same home)

Dental Insurance Information

Primary Dental: _____
Policy holder's name: _____
Policy#: _____ Group#:_____
Address: _____

Secondary: _____
Policy holder's name: _____
Policy#: _____ Group#: _____
Address: _____

Who may we thank for referring you to our office? _____

Medical History: Name of Physician: _____
Is your child currently taking any medications? _____ If yes, what?_____
Has your child ever had a traumatic medical or dental injury?___ If yes, what?_____
Has your child ever been hospitalized?____ If yes, for what?_____ date_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING? (Please circle ALL that apply)

Autism
ADHD
Aids
Allergies
Anemia
Artificial Joints
Asthma
Blood Disease/ disorder
Blood Transfusion
If yes, date_____
Behavioral/ learning Disorders
Breathing/ lung Problems
Cancer/ Tumor
Congenital birth Defects_____
Multiple ear infections

Tubes in ears
Endocrine system
Fainting
Hearing/ Sight
Heart Murmur
Heart Condition
Head Injury
Frequent headaches
Kidney Disease
Liver Disease
Mental Disorder
Developmental Delay
GI System
Radiation Treatment
Respiratory Treatment
Respiratory Problems
Rheumatic Fever
Seizures

Tuberculosis
Down Syndrome
Vomiting/ Diarrhea

Allergies/Adverse reaction to medication?
If yes, what type
_____

Frequent infections?
What type?_____

Any other medical conditions not listed?
_____

None of the above

I have read the above and answered them to my best knowledge. I have updated this form as requested.

Signature_____ Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I understand that under the health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can be used to, but are not excluded to:

- Conduct plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may conduct this organization at any time at the address above to obtain a current copy of Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name_____

Name of Parent of responsible party_____

Relationship to Patient_____

Signature_____

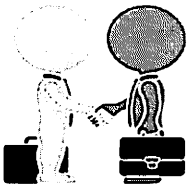
Date_____

Office use only

I attempted to obtain patient's signature in acknowledgment of this Notice of privacy Practices Acknowledgment, but was unable to do so as documented below

Date_____ Initials_____ Reason_____

Cedar View Pediatric Dentistry



Office Policy
&
Financial Agreement

Please read this document in its entirety before signing.

Patients Name: _____

Understanding your dental insurance/Financial Agreement:
We realize that insurances can be confusing and complex, so we have prepared this document to better inform our patient's (parents of) with some general insurance guidelines. The most common misconception about an insurance is that patients think their insurance will cover everything. **Insurance's are not designed to cover all of your dental care.** Most contractual agreements between you and your dental plan require various maximums, limitations, co-pays, and/or deductibles. The premiums paid to insurance companies, have nothing to do with the actual fees or services rendered.

As a service to our patient's, we will work with your insurance company to give you the most accurate co-pay for your visit. **The co-pay provided to you by our office is an estimate only, and is due on the date of service.** Once we receive payment from your insurance company, you will be responsible for paying any additional charges.

If you have received a new insurance, secondary insurance, or if an insurance has terminated or changed, it is your responsibility to update and/or bring in the correct dental insurance card and relay any and all information to our office that may be needed to bill your insurance correctly.

Patient's with no insurance are responsible for paying the full amount of services rendered on that day of service. As a service to our patients, our office will not charge for any x-rays taken if a patient does not carry any dental insurance. In addition to this, we will also give a 10% discount to our patients without dental insurance. **These discounts are only provided when payment is made in full on the date of service.**

Medicaid/Chip Insurance:
Our office accepts the following government assisted insurances: Utah Medicaid with the ACO of: Molina, Select Health, Health Choice, traditional Medicaid; Premier Access Plan A, B, C and I; Nevada Medicaid; United Health Care of Arizona (Arizona Medicaid). **Our office cannot accept any other Utah Medicaid ACO's outside of Iron County.** Our doctors are contracted with the insurances mentioned, and will abide by all of our contractual agreements and guidelines with them. Though these insurances are provided by the state, they are not designed to cover all of a patient's dental care. **It is the patient's (parents of) responsibility to know what their insurance covers.**

Missed Appointments:
Patients are required to cancel or reschedule at least 24 hours before their appointment. We have a long waiting list of patients that are trying to get in for various appointment times. Therefore, **if anyone misses an appointment, they will be charged a missed appointment fee of $25.00 that must be paid in full before the patient can reschedule. If a patient misses an appointment for a sedation in our office, there will be a missed appointment fee of $50.00 that must be paid in full before rescheduling.**
Patient's that are schedule for surgery at Cedar Surgical Center or Cedar City Hospital, must give 48 hour notice if they need to cancel or reschedule. If a patient's appointment is missed at either of these two facilities, the patient (parents of) will be charge a $100.00 missed surgery fee.
This policy applies to everyone, no matter what type of insurance the patient may carry, or even if the patient is not insured.

By signing, you are agreeing to everything stated in this document in its entirety. Our office reserves all rights to modify or update any information contained thereof.

_____	_____	_____
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date