

WELCOME

Welcome to Primary Dental, we are pleased that you have chosen us for your dental needs.

OFFICE HOURS:

Monday – Wednesday	8 a.m – 5 p.m.
Thursday	8 a.m. – 6 p.m.
Friday (every other)	8 a.m. – 12 p.m.

APPOINTMENTS:

We will work with you to schedule appointments that are most convenient for you.

____We highly recommend that you schedule your next appointment before leaving the office. This will allow you to pick the day and time that suits you the best. As a courtesy we call one week prior to your appointment to remind you of the date and time. We will also call you the day before to confirm your appointment. So it is important for you to inform us if your phone number changes. This will allow us to keep your records current.

____We ask that you show up 10 minutes prior to your appointment to do any necessary updates. Showing up late for an appointment may result in cancellation or having to reschedule. Not attending your appointment without notifying us in advance is considered a broken appointment. This may cause a cancellation fee and difficulty scheduling future appointments. After two broken appointments, we will no longer be able to schedule an exact time for treatment. You will need to call at 8:00 or 1:00 to check for availability in that days schedule.

____Some appointments require a deposit: Larger, more comprehensive treatment plans scheduled for more than an hour require a **\$100 deposit**. This deposit goes toward the cost of treatment, but is non refundable if the appointment is cancelled or rescheduled without a 48 hour notice.

____If you need to reschedule/cancel an existing appointment, we ask for **24 hour notice** for an appointment of 1 hour or less. For appointments that are over 1 hour, we need **48 hour notice**. This will allow us to help other patients who are trying to get an appointment. If this policy is not followed, a **\$50 cancellation fee** will be charged to your account.

CHILDREN:

If your child needs to return for treatment, we ask that you please follow these instructions to help make your child's visit a positive one.

1. Give your child Motrin or Tylenol 1 hour prior to the appointment.
2. Keep a positive attitude, your child's attitude depends on yours. Stay positive and reassure them that everything will be ok. Remember if you are negative your child will be negative.
3. Make sure that your child is well rested for their appointment.
4. We ask that you make arrangements for other children that are not being treated. If you need to bring other children please bring things to entertain those children while your child is being treated.

In order for us to maintain the highest quality of service it is important that you follow these instructions.

PAYMENTS:

____We accept most major insurance plans and will file claims for you as a courtesy. However payment/co-pay is due at the time of service.

We accept Visa, MasterCard, *Care Credit** and Cash. **NO CHECKS**. Patients of record that are uninsured and pay with cash or credit card at time of service will receive a 20% discount.

____Remember we only quote estimates of what your insurance will reimburse and your out of pocket cost.

____**For Medicaid patients:** We are required to report all missed appointments to Medicaid. On the second violation, Medicaid may do a welfare check on your child. To avoid this, we strongly urge you to reschedule or cancel your dental appointments in the timely manner stated in our policy.

*Care Credit – A line of credit that offers NO INTEREST payment plans. There will be no interest assessed if the amount is paid within the promotional period. Otherwise interest is assessed from purchase date. Minimum monthly payments required. Subject to credit approval.

Please sign X _____

Primary Dental Patient Information

Please fill out this form completely

Patient Information

Patient's Name Prefers to be Called Date of Birth M F

Address City State Zip Code Home Telephone Number

Medical History

Family Physician _____
Name Address City Phone Number

Date of last physical exam _____ Findings? _____

Does patient have an illness now? Yes No If yes, explain: _____

Has patient ever been hospitalized? Yes No If yes, explain: _____

Is patient presently under a physician's care? Yes No If yes, explain: _____

Allergic to any medication or allergic to anything else? _____ Type of reaction? _____

Taking any medication? Yes No If yes, explain: _____

If patient is a female, is she currently pregnant? Yes No If yes, when is the due date? _____

Has patient had any history of: (Circle those that apply)

Heart Murmurs	Blood Transfusions	Endocrine System Disorder	Liver Disease
Heart Trouble	Dates of Blood Transfusions: _____	Epilepsy	Lung Disease
AIDS	Breathing Problems	Eye or Sight Problems	Mental Retardation
Anemia	Congenital Birth Defects	Excessive Bleeding	Recurrent Headaches
Asthma	Convulsions/Seizures	Hearing Problems	Rheumatic Fever
Bacterial or Viral Infection	Diabetes	Jaundice	Speech Impediment
Behavioral Problems	Digestive System Disorders	Kidney Problems	TMJ Problems
Blood Disease	Emotional Problem	Learning Problems	Tumors/Cancer
Others (please list) _____			

Is there anything else that we should know about the patients medical history? _____

Dental History

Is this patient's first dental visit? Yes No _____

Previous Dentist City Date of Last Visit X-Rays

What is the reason that patient is here for dental care? _____

Is there now or has there ever been any of the following? (Please circle)

Cavities	Toothache	Pain	Broken Tooth
Extracted Teeth	Straightened Teeth	Gum Infection	Mouth Injuries

Has patient had a history of: (Please circle)

Thumb Sucking	Finger Sucking	Lip Sucking	Teeth Grinding
Nail Biting	Prolonged use of bottle and/or breast feeding	Smoking	

Has patient ever had an unfavorable medical or dental experience? Yes No

If yes, please explain: _____

Does the patient brush regularly? Yes No Does the patient use dental floss? Yes No

Responsible Party

Mother's Name

Name of Friend/Relative (in case of emergency)

Address

Address

City State Zip

City State Zip

Social Security Number Birthdate

Home Phone # Cell/Alt Phone#

Home Phone # Cell/Alt Phone #

Employer Work Phone #

Insurance Information

Insurance Company (Primary)

Phone #

Group #/ID #

Insured Person's Name

SS #

Birthdate

Address (if different from patient)

City

State Zip

Phone #

Insurance Company (Secondary)

Phone #

Group #/ID #

Insured Person's Name

SS #

Birthdate

Address (if different from patient)

City

State Zip

Phone #

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED. If my account requires servicing by a collection agency or by an attorney I understand that I will be liable for the collection fees, attorney fees, applicable court costs and a monthly finance charge of 1.5% (18% annually) will be assessed on remaining balance. I also request that payment under my dental insurance program be made directly to Primary Dental on any unpaid bills for services furnished by me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

Patient Initial _____

I understand that Primary Dental requests a 24 hour notice prior to a cancellation of any appointment. I understand there is a fifty dollar cancellation fee after my first missed appointment. After three appointments that are cancelled without a 24 hour notice, I understand that Primary Dental will no longer be able to see me or my child. I understand that doctors Chad Williamson and Les Maes are general dentists.

Patient Initial _____

I give the doctors permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my self. This would include an oral examination, radiographs (X-Rays) and other diagnostic aids. I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions that me or medical doctor had advised me should be reported to a dentist.

Signature

Relationship to Child

Date

Reviewed By: Doctor

Date

**Primary Dental
Lakeside Center
5801 W. 44th Avenue
Suite D-160
Denver, CO 80212**

**INFORMED CONSENT
FOR PATIENT MANAGEMENT TECHNIQUES**

Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it.

Our goal is to provide the best possible dental care to each child patient, however, providing high quality of care can sometimes be compromised, made difficult, or even sometimes impossible, due to the lack of cooperation by a child patient. Among the behaviors that can interfere with our professional care being delivered to a child include, but are not limited to: hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform necessary dental treatment, aggressive or physical resistance to treatment, which may include kicking screaming and grabbing the dentist and/or his assistants hands which may hold sharp dental instruments.

All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In the event we cannot obtain the cooperation of the child, there are several alternatives in behavior management techniques that may be used to gain cooperation of the child to eliminate disruptive behavior or prevent patient from causing injury to him/herself or the staff due to uncontrollable movements.

Local anesthesia is used in operative procedures general anesthesia is never used in this office. Nitrous Oxide Analgesia may be used at a minimal level, but the child is never unconscious while under our care.

If you have any questions, please feel free to talk to the Primary Dental doctors at any time.

There are several behavior management techniques that are used by dentists to gain the cooperation of child patients to eliminate disruptive or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are on the back of this form.

Please indicate if you understand these techniques by marking the appropriate box.

- Yes No 1. **Tell- show-do:** The dentist or dental assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
- Yes No 2. **Positive reinforcement:** The technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, and a pat on the back, a hug or a prize.
- Yes No 3. **Voice control:** The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.
- Yes No 4. **Mouth prop:** A rubber or plastic device is placed in the child's mouth to prevent closing during operative procedures.
- Yes No 5. **Physical restraint by the dentist:** The dentist restrains the child from movement by holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body, or positioning the child firmly in the dental chair.
- Yes No 6. **Physical restraint by the assistant:** The assistant restrains the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movements.
- Yes No 7. **N2O Gas:** Sometimes Nitrous is used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. Nitrous is used solely as a relaxing agent. At no time will the child be unconscious.

I acknowledge that I have read and understand the Informed Consent for Patient Management Techniques, and that all questions about the behavior management techniques and alternatives have been answered in a satisfactory manner. I further understand that I have a right to be provided with answers to any questions that may arise during the course of my child's treatment.

I hereby authorize and direct the doctors of Primary Dental assisted by the dental auxiliaries of his/her choice, to utilize the behavior management techniques listed above to assist in the provision of the necessary dental treatment for my child or legal ward.

If you have any exceptions please list and talk to the doctors.

I further understand that this consent shall remain in effect until terminated by me.

Patient's name: _____

Signature of Parent or guardian: _____ Date _____

Primary Dental

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: TO THE PATIENT/PARENT/GUARDIAN---PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent our use and disclosure of you protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting any one of our staff members at:

Primary Dental
5801 w 44th Ave. Suite D-160
Denver, Co. 80212
Telephone #: 303-433-1239 or Fax# 303-455-5317

SECTION B: PATIENT GIVING CONSENT

Patient name: _____

Date of Birth : _____

Right to revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the office listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and we may decline to treat you if you revoke this Consent.

SIGNATURE

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care options.

Signature: _____ **Date:** _____

Printed name: _____

Relationship to Patient _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
