COUNTRYCLUBDENTAL
FLAGSTAFF

Welcome, kids!

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

ABOUT YOUR CHILD:

Today's Dote: _____ / _____ / _____

Child's Name: _____

NickName: _____

Birthdate: _____ / _____ / _____ Age: _____

SS#: _____ ❍ Male ❍ Female

School: _____ Grade:_____

Home Address: _____

_____

Email: _____

Hm: (_____) _____

ACCOMPANYING THE CHILD TODAY:

Name: _____ Relation: _____

Do you have legal custody of this child? ❍ Yes ❍ No

Is child adopted? ❍ Yes ❍ No In a foster home? ❍ Yes ❍ No

Whom may we thank for referring you? _____

Other siblings seen by us:_____

Previous / Present Dentist: _____

Last Visit Date: _____ / _____ / _____

Parent's Marital Status:

❍ Single ❍ Married ❍ Divorced ❍ Widowed ❍ Separated

PARENT'S INFORMATION:

❍ Mother ❍ Step Mother ❍ Guardian

Name: _____ Birthdate: _____ / _____ / _____

Cell: (_____) _____ Hm: (_____) _____

Employer: _____ Wk: (_____) _____

❍ Father ❍ Step Father ❍ Guardian

Name: _____ Birthdate: _____ / _____ / _____

Cell: (_____) _____ Hm: (_____) _____

Employer: _____ Wk: (_____) _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relation: _____

Billing Address: _____

_____

Wk: (_____) _____ Ext: _____

Hm: (_____) _____

SS#: _____ or DL# : _____

INSURANCE INFORMATION:

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone#: (_____) _____

Group# : _____

Member ID# : _____

Policy Holder's Name: _____ Relation: _____

Birthdate: _____ / _____ / _____

Employer: _____

Employer's Phone#: (_____) _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone#: (_____) _____

Group# : _____

Member ID# : _____

Policy Holder's Name: _____ Relation: _____

Birthdate: _____ / _____ / _____

Employer: _____

Employer's Phone#: (_____) _____

WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY:

_____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ❍ Yes ❍ No

Please explain: _____

Is the child's water fluoridated? ❍ Yes ❍ No

Is the child taking fluoridated supplements? ❍ Yes ❍ No

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

Does the child brush his / her teeth daily? ❍ Yes ❍ No

Does the child floss his / her teeth daily? ❍ Yes ❍ No

Child's Physician: _____

Last Visit Date: _____ / _____ / _____

Is the child currently under the care of a physician?
❍ Yes ❍ No

Please describe the child's current physical health:
❍ Good ❍ Fair ❍ Poor

Hos the child ever taken Fosomox, Aclonel, Boniva or any other bisphosphonate? ❍ Yes ❍ No

Please list all drugs that the child is currently taking:

_____

_____

Aside from items listed below, list all drugs / things the child is allergic to:

_____

_____

Latex? ❍ Yes ❍ No Metals? ❍ Yes ❍ No

Plastics? ❍ Yes ❍ No

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS:

❒ Abnormal Bleeding
❒ ADD/ ADHD
❒ Anemia
❒ Any Hospital Stays
❒ Any Operations
❒ Artificial Bones / Joints / Valves
❒ Asthma
❒ Cancer
❒ Chicken Pox
❒ Congenital Heart Defect
❒ Convulsions
❒ Diabetes
❒ Epilepsy
❒ Exposed to HIV, but Neg.
❒ Handicaps/ Disabilities
❒ Hearing Impairment
❒ Heart Murmur
❒ Hemophilia
❒ Hepatitis
❒ Hives
❒ HIV+ / AIDS
❒ Kidney / Liver Problem
❒ Measles
❒ Mononucleosis
❒ Rheumatic / Scarlet ever
❒ Sickle Cell Disease / Traits
❒ Skin Rash
❒ Tuberculoses (TB)

Are the Child's Immunizations current? ❍ Yes ❍ No

Please discuss any serious medical problems that the child has had:

_____

_____

Does / did the child experience any of the following?

❒ Lip Sucking / Biting
❒ Nail Biting
❒ Nursing Bottle Habits
❒ Thumb/ Finger Sucking

Was the child breast fed? ❍ Yes ❍ No

Our office is HIPAA Compliant and is committed lo meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

My method of payment will be: _____

_____
Signature of Parent / Guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been approved.

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. Whitney all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deducible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent / Guardian Date

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian Named herein.

Initials: _____ Date: _____ / _____ / _____

Doctor's Comments: _____

_____

_____

MEDICAL HISTORY UPDATE:

Date: _____ Signature: _____

Comments: _____

Date: _____ Signature: _____

Comments: _____

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CONTINENTAL PLAZA, SUITE C-4
5200 E CORTLAND BOULEVARD,
FLAGSTAFF, AZ 86004

P: 928.526.4314 F: 928.714.1475

CountryClubDentalFlagstaff.com

OFFICE POLICIES

Welcome

In order to serve you better, please note the following office policies:

ALL fees, insurance deductibles and/or co-payments are due at the time of service unless prior arrangements have been made with the office management. We offer to bill your insurance carrier for you as long as we have complete billing information and your signature on file. Therefore, your signature below acknowledges the following:

INITIAL Regardless of your insurance coverage, all fees are ultimately your responsibility. We attempt to provide for you accurate estimates of your insurance benefits; however, you are responsible for all treatment fees regardless of the accuracy of our estimates given to you.

INITIAL Please notify us if a full set of dental x-rays or a panoramic x-ray has been taken within the last 5 years. Most insurance companies will NOT pay for another set within that time frame. Copies of readable/diagnostic x-rays need to be obtained from a previous dental office pending your request.

INITIAL We provide composite (white) fillings on all adult teeth. Some insurance companies will only allow the silver benefit. It will be your responsibility for the difference if such an allowance is made.

A $30.00 fee is charged for all returned checks.

INITIAL Effective 7/1/15: Our C.P.A. firm has implemented a new policy on delinquent accounts. If an account is 90 days past due, with no payments having been made during that time, the account will immediately go into the collections process. If you are unable to pay the balance in full it is your responsibility to contact the office upon statement receipt to discuss payment options. Any collection and/or legal fees incurred will be your responsibility. Costs of collection include, without limitation, all fees charged by a collection agency, attorney fees, small claims court costs and any other costs incurred in the effort to collect your debt.

INITIAL We provide a courtesy call approximately 48 hours prior to your appointment. HOWEVER, this is a courtesy and you are responsible to keep or cancel your appointment whether or not you were contacted. Please cancel and/or change within 48 hours prior to the appointment. There will be a $50.00 per hour charge for all missed appointments without appropriate notice, respective to your situation.

Thank you very much!

SIGNATURE

DATE

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DENTAL INSURANCE / FINANCIAL ARRANGEMENT

Payment is due at the time services are rendered unless payment arrangements have been approved in advance by our management staff.

If you have dental insurance, we will do everything we can to help you receive your maximum allowable benefit. In order to achieve this goal, we need you to take the necessary steps to understand your insurance plan. There are numerous different providers, plans and groups available. The following are key points in regards to your insurance you must be clear on:

- Your insurance policy is a contract between you and the insurance company. We are not a party to that contract.
- Most insurance policies have a yearly deductible, understand what that amount is as that is your financial responsibility.
- Most insurance policies only pay a percentage of the cost of your treatment, you are responsible for the remaining balance on your account after insurance pays/denies their portion.
- Not all services are a covered benefit, be familiar with what these services are.
- As a courtesy for you, we will submit all claims to your insurance company. However, if for any reason the claim is unpaid, you are responsible for all the charges incurred.

Please ask us, your human resources (HR) department and/or your insurance company. We are here to help you in any way we can!

I, , am financially responsible for any and all charges on my account. I have read and I understand the above information.

SIGNATURE

DATE

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 April 14, 2003, and will remain in effect until were place 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.

For more information about our privacy practices, or to request a copy of our Notice, please contact us using the information listed on this website.

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 pickup 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,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.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence,and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information,with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. We may charge you a reasonable cost-based fee for expenses such as copies and staff time. If you request an alternative format,we will charge a cost-based fee for providing your health information in that format.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations, and certain other activities, but not before April 14, 2003. If you request this accounting more than once in a 12-monthperiod,we may charge you a reasonable,cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do,we will abide by our agreement, except in an emergency.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations.{You must make your request in writing.}Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request. Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the address or phone number provided on this website.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information, or in response to a request you made to amend or restrict the use or disclosure of your health information, or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed on this website. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in anyway if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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ACKNOWLEDGEMENT RECEIPT & NOTICE OF PRIVACY PRACTICE

You may refuse to sign this acknowledgement.

I, . , have received a copy of this office's Notice of Privacy Practice.

SIGNATURE DATE

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, 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)**

EMAIL FORM