

# Child Health / Dental History Form

Please complete the following information for your child - Both Page 1 and 2

Patient Name:	Last,	First	MI	(Preferred Name)	Date:
Social Security #:				Birth Date:	
Phone (Home):	(Work):	(Cell):			
Address:	Street	City	State	Zip Code	
Emergency Contact:	Name	Phone Number		Relationship	

## Child Medical History

Has your child ever had any of the following? Please check those that apply:

- |   |  |   |  |
|---|--|---|--|
| <input type="checkbox"/> Allergies _____      | <input type="checkbox"/> Fainting Spells     | <input type="checkbox"/> Mitral Valve Prolapse  | <input type="checkbox"/> Other Medical Condition |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Nervous Disorders      | Explain: _____                                   |
| <input type="checkbox"/> Artificial Joints    | <input type="checkbox"/> Growths/Tumors      | <input type="checkbox"/> Radiation Treatment    |  |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Reaction to Anesthetic |  |
| <input type="checkbox"/> Bleeding Tendencies  | <input type="checkbox"/> Heart Conditions    | <input type="checkbox"/> Rheumatic Fever        |  |
| <input type="checkbox"/> Blood Disease        | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Sinus Problems         |  |
| <input type="checkbox"/> Cancer               | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Steroid Therapy        |  |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Stroke                 |  |
| <input type="checkbox"/> Emphysema            | <input type="checkbox"/> Growths/Tumors      | <input type="checkbox"/> Tuberculosis           |  |
| <input type="checkbox"/> Epilepsy/Convulsions | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Ulcers                 |  |
|   | <input type="checkbox"/> Liver Disease       |   |  |

### Yes No

- Has your child ever been admitted to a hospital? If so, for what? \_\_\_\_\_
- Is your child under active treatment by a physician? If so, for what? \_\_\_\_\_
- Is your child taking any drugs or medications? If so, what? \_\_\_\_\_
- Is your child allergic or has he/she reacted adversely to any medications? If so, what? \_\_\_\_\_
- Has your child ever had a serious illness? If so, what? \_\_\_\_\_

## Child Dental History

### Yes No

- Does your child currently have teeth that are painful?
- Has your child ever been to the dentist before? If not the first visit, what was the date of the last visit? \_\_\_\_\_
- Has your child had any difficulties with dental treatment in the past? Please explain: \_\_\_\_\_
- Has your child ever been sedated prior to dental treatment?
- Has your child ever suffered any injuries to the mouth, head, or teeth?
- Has your child previously had any orthodontic work performed (braces or space maintainers)?
- Does your child suck his or her thumb or sleep with a pacifier?

### Please circle the appropriate response

My child's teeth are brushed: not sure / occasionally / once daily / twice daily

My child brushes his/her teeth: alone / with assistance from a parent

My child brushes with fluoridated toothpaste: yes / no / not sure

Reason for today's visit or any specific concerns: \_\_\_\_\_

I certify that all health information above is correct: \_\_\_\_\_

Parent/Guardian Signature Date

Doctor Review Date

## Referral Information

Whom may we thank for referring you to our practice?

- Another patient - Name: \_\_\_\_\_  Another Dental Office - Name: \_\_\_\_\_
- Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_

Office Use - In the future, please advise us of any changes in your child's medical history or any new medications. Continue to P.2

Date of Review: Changes to child's health history? Parent Initial:

- |                              |                             |       |
|------------------------------|-----------------------------|-------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | _____ |

## Guarantor Information

Who is responsible for this account? \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Insurance Information (if applicable)

### Primary Insurance

Name of Insured: \_\_\_\_\_ Is insured a patient?  Yes  No  
Insured's Birth Date: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

### Secondary Insurance

Name of Insured: \_\_\_\_\_  
Insured's Birth Date: \_\_\_\_\_ Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_ Group #: \_\_\_\_\_  
Insured's Address: \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Insured's Employer Name: \_\_\_\_\_  
Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_  
Insurance Plan Name and Address: \_\_\_\_\_

## Agreement and Consent for Services

### Acknowledgement of Accurate Information

To the best of my knowledge, the questions on the two pages of this form have been answered accurately. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes to my medical status or history. If I have any change in my medical status or medications I take, I will inform the Hygienist or Doctor at my next appointment.

### Consent To Proceed

By signing this form, I freely give my consent to allow and authorize Dr. Larsen, his hygienists and or such associates or assistants as he may designate to perform the procedures as may be deemed necessary or advisable to maintain my (or the patient's) dental health or the dental health of any minor or other individual for which I have responsibility, including administration of any sedative (including nitrous oxide), analgesic, therapeutic, and or other pharmaceutical agent(s). The benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, to achieve these benefits, there are inherent risks associated with virtually any dental procedure including but not limited to: (1) Drug or chemical reactions. Dental materials and medications may trigger allergic or sensitivity reactions. (2) Long term numbness. Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in prolonged or in rare instances, permanent numbness. (3) Muscle or joint tenderness. Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, precipitate a jaw joint disorder. (4) Sensitivity in teeth or gums. (5) Damage to teeth, gum, or bone structures. (6) Bleeding, swelling, infection. (7) Swallowing or inhaling small objects. (8) Bruising, hematoma, cardiac stimulation, muscle soreness, irritations of soft tissues or other body parts.

I do voluntarily assume any and all possible risks (or the patient's), including the risk of substantial and serious harm, if any, which may be associated with dental treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit and the benefit of my minor child or ward. While we follow procedural guidelines, which most often lead to a clinical success, just like in any other pursuit in health care, no procedural outcome can be guaranteed.

I have read the above conditions of treatment and agree to their content.

I have read the above conditions of payment and conditions of treatment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent, or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

# Financial, Insurance, and Missed Appointment Policy – Larsen Dental



## **1. If You Are Covered By Insurance**

As the patient receiving the benefit of treatment, you (or your “responsible party”) are ultimately financially responsible for all dental services received, regardless of your insurance coverage. Insurance is a contract between you and your insurance company and our office is not a party to that contract. Our practice does not guarantee that your insurance company will pay for treatment you receive. As a courtesy, our office may assist with pre-authorizations and help to file your insurance claims. However, even though we are filing these claims in your behalf, we do not accept responsibility for the outcome of these transactions. The responsibility for full payment remains with you as the beneficiary of the services. If payment is not received from your insurance company within 60 days of the date of service, you will be expected to pay any outstanding balance in full.

Patients with insurance are expected to make a down payment (co-payment) at the time of service. This down payment amount is based on our experience and is merely an ESTIMATE of the portion that will not be covered by your insurance. After your insurance pays its portion of the claim amount, this down payment (co-payment), may be found to be insufficient to cover the remaining balance. You will then be responsible for payment of the balance. Similarly, any overpayment will be applied to future treatment or refunded to you.

## **2. If You Are Not Covered By Insurance**

Patients without insurance are expected to make payment in full for all charges at the time of service unless prior financial arrangements have been made. Financial arrangements with our office must be made in advance of treatment.

## **3. Payment Options and Considerations**

Payments may be made with VISA, MasterCard, Discover, CareCredit, debit card, cash or personal check. A \$30.00 service charge is assessed on all checks returned unpaid by your bank. A service charge of 1.5% per month (18% annually) will be assessed for account balances that extend past 60 days. Charges for mailing statements may also apply.

Delinquent accounts (over 90-days due) will be referred to a collection agency at our discretion. If a collection referral becomes necessary, the undersigned agrees to pay all costs including reasonable attorney fees to effect payment. By signing this agreement, you give permission to our office to telephone you on your cell phone, at home or at work to discuss matters related to collection or this form.

## **4. Insurance Authorization**

With my signature below, I hereby authorize release of any relevant information necessary to process my claim to

my insurance company. I also authorize any insurance benefits otherwise payable to me to be paid directly to David W. Larsen DMD LLC for services provided.

## **5. Deposit Policy**

For some procedures, a deposit may be required to reserve the appointment time. In the event of a “missed appointment” without two-business days notice, the deposit will be forfeited and will not be applied to any other treatment fee.

## **6. Missed Appointment Policy**

Your scheduled appointment is a reservation. Our office reserves the appointment time just for you. If you need to re-schedule an appointment, we ask that you provide two business days' notice to make changes to your reserved appointment time.

A “missed appointment” is defined as not arriving for a scheduled appointment, cancelling an appointment with less than two business days’ notice, or arriving more than 10 minutes late. Patients who repeatedly miss appointments, increase the cost of providing healthcare to everyone and jeopardize their professional relationship with our office. Our missed appointment policy follows:

- After two “missed appointments” (in a 24-month period) in which two business days has not been given, you may be charged a \$25 fee or the office may require you to pay a deposit before we reserve your next appointment. The deposit fee will be applied to any treatment rendered or forfeited if your reserved appointment is “missed.”
- Appointment Reminders: As a courtesy to our patients, our office will generally send text reminders to patients two weeks prior to a re-occurring hygiene appointment or a phone call at one week prior. If the appointment time needs to be re-scheduled, we ask that call our office to make the scheduling change with at least two business days' notice.

## **7. Acknowledgement**

This policy form represents an agreement between you as the patient and our office. It is intended to facilitate our ability to provide excellent service to you while minimizing administrative expenses. I acknowledge that I have read this agreement and agree with it.

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Signature - Patient/ Responsible Party

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Date

**DAVID W. LARSEN, DMD**

**CONSENT FOR USE AND DISCLOSURE  
OF HEALTH INFORMATION**

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your 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, the uses and disclosures we may make of your protected health information, and other important matters about your protected health information. A copy of our Notice is available in the office. 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, including any revisions of our Notice, at any time, by asking for one.

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person 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 that we may decline to treat you or to continue treating 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: \_\_\_\_\_

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

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

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# **David W. Larsen D.M.D. / Larsen Dental**

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## **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.**

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**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 practice, our legal duties, and your rights concerning your health information. We must follow the privacy practice that are described in this Notice while it is in effect. This Notice takes effect April 15, 2003, 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 and 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.

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### **USES AND DISCLOSURE OF YOUR HEALTH INFORMATION**

We may use and disclose health information about you for treatment, payment and healthcare operations. For example:

**Another Healthcare Provider Who May Provide You Treatment:** We may use or disclose your health information to a physician, another dental provider, or another healthcare provider who may provide treatment to you. This most often happens in the form of a referral to a dental specialist for consultation or treatment. This may also happen in the form of transferring your records to a new dental provider. Your dental radiographs are the most common requested health information requested by a subsequent provider. We may choose not to use a formal encryption or password-required platforms to transfer radiographs. This means theoretically, a third-party such as an internet, email, text, or phone provider theoretically could have access to your dental radiographs.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you. This most often happens in working with your dental insurance company to collect payment in your behalf. This may also happen in the form of working with an outside collection agency to collect an overdue balance.

**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 of 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, with payment for your healthcare, or with scheduling.

**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 disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based a determination using our profession 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.

**Education and Marketing Health-Related Services:** We will not use your identifying health information for marketing communications without your written authorization. We may use radiographs, models, and isolated intraoral and extraoral pictures for

education, dental study groups, patient education, and marketing purposes to the extent that they do not specifically identify you and that your identity remains anonymous.

**As 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.

**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 through such mediums as voicemail messages, postcards, letters, emails, or texts. For appointment reminders, we may choose not to use a formal encryption or password-required platforms to notify or remind you of upcoming appointments. This means a third-party such as an internet, email, text, or phone provider theoretically could have access to your appointment reminders. Additional information such as medications needed to be taken prior to the appointment may be included in these communications as well.

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## 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. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you \$0.50 for each page, \$10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

**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, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, 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.

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## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or 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 at the end of this Notice. 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 any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

**Contact Officer:** Dr. David Larsen

**Telephone:** 970-242-2717

**Address:** 1655 North 1<sup>st</sup> Street, Grand Junction, CO 81501