CANYON RIDGE Pediatric Dentistry

Dental Specialist for Colorado's Kids

Patient Name: _____ Preferred name: _____ Male/Female

Patient DOB: _____ Patient lives with: _____

Parent/Legal Guardian Information: Legal Custody: YES/ NO

Name: _____

Relationship to Patient: _____

Marital Status: _____ DOB: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Parent/Legal Guardian Information: Legal Custody: YES/ NO

Name: _____

Relationship to Patient: _____

Marital Status: _____ DOB: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Preferred Primary Contact: _____ **Preferred Contact Phone:** _____

Preferred Contact Email: _____

Primary Insurance Information

Subscriber's Name: _____

DOB: _____ Social Security No: _____

Employer: _____

Insurance Provider: _____

Insurance Phone: _____

Member ID # _____

Group # _____

Secondary Insurance Information

Subscriber's Name: _____

DOB: _____ Social Security No: _____

Employer: _____

Insurance Provider: _____

Insurance Phone: _____

Member ID # _____

Group # _____

Please thoroughly read the following health information questions and check YES or NO.

	YES	NO		YES	NO
Does your child have heart disease, heart murmur or ever had heart surgery?			Is your child taking medication, been hospitalized or had a surgery for any other condition(s)?		
Has your child been told they need to take antibiotics prior to dental work?			Does your child have any other medical condition(s) or syndrome?		
Does you child have any allergies? If yes, allergic to what? _____			Has your child had any surgeries? If yes, when and what for? _____		
Does your child have GI disease including acid reflux, Crohn's Disease, etc.?			Has your child ever been diagnosed with cancer, leukemia or a tumor?		
Has your child ever had abnormal bleeding, anemia or a blood transfusion?			Has your child ever had lung disease including asthma, pneumonia, RSV or tuberculosis?		
Is your child taking any drugs or medicine now? If yes what? _____			Does your child have any mental, physical or emotional special needs? If yes, please explain _____		
Has your child had an unfavorable reaction to medical or dental treatment?			Does your child us a bottle/sippy cup at night?		
Does your child have a hormonal disease including diabetes or thyroid disease?			Does your child have a thumb or pacifier habit?		
Has your child been diagnosed with liver or kidney disease?			Is this your child's first dental visit?		

How did you find out about our office? _____

As the parent/legal guardian of the above minor patient, I hereby authorize treatment by Dr. Marc D. Thomas and his dental staff. I have been given the opportunity to decline any service which I do not want my child to receive. Any additional treatment will be presented to me prior to treatment being performed. I confirm the medical history is correct and understand that a detailed medical history helps ensure safe dental treatment. I agree that I am responsible for payment of any services not paid by my insurance company. I authorize payment of my dental benefits to Marc D. Thomas, DDS, PC/ Canyon Ridge Pediatric Dentistry.

_____ _____

Parent or legal guardian signature Date

CANYON RIDGE
Pediatric Dentistry
Dental Specialist for Colorado's Kids

Financial Policy

We are pleased to welcome you to our practice. Our goal is to assist your child in achieving optimum oral health in a warm and caring environment. It is our policy to make definite financial arrangements with you before any treatment begins. Below is an explanation of our financial policy. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards (Visa, MasterCard, Discover and American Express).

2. For new patient emergency visits we require payment in full at the time of the appointment.

3. As a courtesy, we will provide you with a copy of the charges to submit to your insurance carrier for your reimbursement or you may assign the payment to our office and we will file the insurance for you. The office will accept assignment for only the primary insurance coverage, secondary insurance coverage must be paid to the patient.

4. If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance. We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.

5. You must provide the office with a dental insurance card with the proper mailing address of the insurance company, or provide a dental claim form, which is provided by the employer. If one of these documents is not available at the time of the appointment, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.

6. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.

7. The office cannot carry balances longer than 90 days; regardless if the insurance payment is still pending. After 90 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will be required to employ a collection service to collect payment.

8. There will be a $35.00 service for all returned checks.

9. The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

Authorization

1. I authorize Dr. Marc Thomas and staff to release any information concerning my case to my insurance company.

2. I have read and accept the above Financial Policy, understand it and agree to the terms set forth regarding payment.
3. I authorize payment to be paid directly to Dr. Marc D. Thomas, Canyon Ridge Pediatric Dentistry.

_____ _____

Signature of Parent or Responsible Party: Date:

CANYON RIDGE
Pediatric Dentistry
Dental Specialist for Colorado's Kids

19551 Hess Road, Ste 110
Parker, CO 80134

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgement ****

I,_____ , parent or legal guardian for _____, has
Parent/Legal Guardian Patient's Name
been given the opportunity to review the office's Notice of Privacy Policies.

_____
Please Print Parent or Legal guardian Name

_____
Signature of Parent or Legal Guardian

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practice, but acknowledgment could not be obtained because:

- o Individual refused to sign
- o Communication barriers prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other (Please Specify): _____

COVID-19 PANDEMIC - PATIENT DISCLOSURES

This patient disclosure form seeks information from you that we must consider before making treatment decisions during the COVID-19 virus outbreak

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

	Yes	No
Do you have a fever or above normal temperature?		
Have you experienced shortness of breath or had trouble breathing?		
Do you have a dry cough?		
Do you have a runny nose?		
Have you recently lost or had a reduction in your sense taste or smell?		
Do you have a sore throat?		
Have you been in contact with someone who has tested positive for COVID-19?		
Have you tested positive for COVID-19?		
Have you been tested for COVID-19 and are awaiting results?		
Have you traveled outside the United States by air or cruise ship in the past 14 days?		
Have you traveled within the United States by air, bus or train within the past 14 days?		

I fully understand and acknowledge the above information, risks and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate.

_____ _____

Signature Date

_____

Witness

Dental Treatment Consent and Affirmation Form
COVID-19 Reopening

1. I knowingly and willingly consent to dental treatment at **Canyon Ridge Pediatric Dentistry** by **Dr. Thomas** and any designated associates and employees during the reopening phase of COVID-19.

2. I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms yet are still highly contagious. It is impossible to determine who has COVID-19 and who does not given the current limitations and availability in COVID-19 viral testing.

3. Risk of transmission: I understand that due to the frequency of visits of other care dental patients, characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office, even though standard precautions are being observed.

4. I am unaware of being a possible carrier or infected: I confirm that I have not tested positive for COVID-19 in the last 30 days and that I am not presenting with any of the following symptoms of COVID-19:
   A. Fever of 100.5 degrees Fahrenheit or 37 degrees Celsius or higher
   B. Shortness of breath
   C. Dry cough
   D. Runny nose
   E. Sore throat.
   F. Diminished sense of taste or smell

5. Contact with infected: I confirm that I have not knowingly been in close contact (defined as 6 feet or less for a duration of fifteen minutes or more) with someone who has tested positive for COVID-19 in the last 14 days, or with anyone that has had the above stated symptoms in paragraph 4 (#4) in the last 14 days.

6. Public travel: I confirm that I have not traveled outside of the United States in the past 14 days. I confirm that I have not traveled domestically by commercial airline, bus, or train within the last 14 days.

INFORMED CONSENT: I have been given the opportunity to ask any questions regarding the risks of contracting COVID-19 from the dental office and dental procedures. I reaffirm that I am not a carrier of COVID-19 nor infected with COVID-19 to the best of my knowledge. I voluntarily assume any and all medical/dental risks, including the substantial and significant risk of serious harm, if any, which may be associated with any phase of my treatment as a result of the COVID-19 pandemic. I acknowledge that the nature and purpose of the dental procedures recommended under the current circumstances and restrictions have been explained to me and that I have been given the opportunity to ask questions.

Patient's name (please print)	Signature of patient, legal guardian or authorized representative	Date

Witness to signature	Date