CHILDREN'S DENTISTRY OF COFFEE CREEK - DON CHEATHAM, D.D.S.

DEMOGRAPHIC INFORMATION

Patient's Name: _____ Today's Date: _____
First Middle Last (Preferred)
Birth Date: _____ Age:_____ ☐ Male ☐ Female Patient's Social Security Number: _____
Home Phone: ( )_____ Primary Contact Phone #: ( ) _____
Address: _____
Street/Post Office Box # City State Zip Code
Names and ages of other children in family: _____
Name of School: _____ Grade: _____

Primary Guardian: _____Date of Birth: _____ Social Security #: _____
Cell Phone #: _____ E-mail Address: _____
Employer: _____ Work Phone #: ( ) _____
Relation to Patient: _____

Additional Guardian: _____Date of Birth: _____Social Security #: _____
Cell Phone #: _____ E-mail Address: _____
Employer: _____ Work Phone #: ( ) _____
Relation to Patient: _____

Who has legal custody of patient? ☐ Biological parents ☐ Other (enter info below)

Guardian Name: _____ Guardian DOB: _____ Guardian Phone#: ( ) _____
Guardian Address: _____
Street/Post Office Box # City State Zip Code

Person/persons responsible for payment of account: _____

Do you have dental insurance? ☐ Yes ☐ No Policyholder Name: _____
Name of Insurance Company: _____ ID# _____ Group# _____
Insurance Company Phone #: _____

Who referred you? ☐ Physician _____ ☐ Friend _____ ☐ Other _____

CHILD'S DENTAL HISTORY

What is the reason for your child's visit? _____

Date of your child's last dental exam: _____Date of your child's last cleaning: _____
Date of your child's last xrays: _____

Do you have any concerns with your child's past dental treatment? ☐ Yes ☐ No
If yes, please explain: _____

Is your home water fluoridated? ☐ Yes ☐ No Does your child use a fluoride toothpaste? ☐ Yes ☐ No
Do you give your child any fluoride supplement? ☐ Yes ☐ No
If yes, please explain: _____
Does your child participate in a school fluoride rinse program? ☐ Yes ☐ No

CHILD'S HEALTH HISTORY

Is your child in good health? ☐ Yes ☐ No If no, please explain: _____
Name of child's physician: _____ Physician's phone #: ( )_____
Date of last physical exam: _____ Is your child currently under his/her physician's care? ☐ Yes ☐ No
If yes, please explain: _____

Is your child currently taking any medications, whether prescription or over the counter? ☐ Yes ☐ No
If yes, please explain: _____

Has your child ever had a health problem in the past? ☐ Yes ☐ No
If yes, please explain: _____

Where there any problems at birth? ☐ Yes ☐ No
If yes, please explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No
If yes, please explain and provide dates: _____

Is your child allergic to any medication? ☐ Yes ☐ No
If yes, please name medication: _____

Does your child have any seasonal or environmental allergies? ☐ Yes ☐ No
If yes, please explain: _____

Does your child have any history of the following? Please check if applicable:

☐ ADD/ADHD	☐ Bulimia	☐ Heart Valve Replacement	☐ Prosthesis
☐ Alcohol Use	☐ Cancer	☐ Hepatitis (A, B, or C)	☐ Psychiatric Counseling
☐ Anemia	☐ Cerebral Palsy	☐ Kidney Disorder	☐ Radiation Treatment
☐ Anorexia Nervosa	☐ Cleft lip/palate	☐ Latex Allergy	☐ Rheumatic Fever
☐ Antibiotic Prophylaxis	☐ Cocaine Use	☐ Leukemia	☐ Seizure Disorder
☐ Arthritis	☐ Diabetes	☐ Liver Disorder	☐ Speech/Hearing
☐ Asthma	☐ Dye (ex: Red Dye # 40)	☐ Malignant hyperthermia	☐ Stomach Disorder
☐ Autism	☐ Emphysema	☐ Methamphetamine Use	☐ Tobacco Products
☐ Bleeding (prolonged)	☐ Epilepsy	☐ Nickel Allergy	☐ Tuberculosis
☐ Blood transfusion	☐ Heart Disease	☐ Oral Contraceptives	☐ Venereal Disease
☐ Bronchitis/Pneumonia	☐ Heart Murmur	☐ Pregnant (currently)	☐ Other

☐ **No existing medical conditions**
Please elaborate if any of the above are checked: _____
_____
_____

INSURANCE RELEASE FORM

If you have dental insurance, we will be happy to file your claim through your primary insurance company. We are the third party on all insurance transactions. It is very important to understand the following terms under which we agree to take your insurance assignment:

We are in-network with the following insurance companies: *Delta Dental (all states), Guardian, HealthChoice, AETNA (PPO only), MetLife, Humana PPO, Blue Cross Blue Shield (OK, TX, NM, IL), Cigna, Careington, SoonerCare*

We will file with all other insurance companies, as well, but understand that **you will be responsible for any co-pay that is due** for out of network services. A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service.

1. Please provide us with a copy of your dental insurance card, the cardholder's date of birth and social security number. It is essential that you notify us before treatment and if any changes have taken place with your dental insurance.

2. The parent or guardian is responsible for accompanying their child to dental appointments. **That parent or guardian is also responsible for any payment due for services that day**.

3. You must be aware that all insurance companies reimburse Dr. Cheatham based on "UCR" This means "usual, customary and reasonable" rates as decided upon by your insurance provider. However, we provide care under the specialty of pediatric dentistry. Since our fees are not arbitrarily set, but rather are based on our costs in providing a high caliber of care for your child, our fees may be more than those set by your insurance company.

4. Dental insurance is meant to be an aid in receiving dental care. **The level of compensation that your insurance company will provide is based on whether they are in-network or out-of-network with our office**.

5. **We allow 30 days for a response from your insurance company.** After 30 days, the balance becomes your responsibility. If after two to three weeks you have not received a notice of payment from your insurance company, please contact them and inquire about your child's claim status.

6. After we receive a payment or a notice of non-payment from your insurance carrier, **we will send you a statement if there is a balance due**. Please contact your insurance company first before calling us with any disputes. You will have 30 days in which to make your payment in full. **Parents are responsible for any deficiencies in the insurance coverage and any charges not paid by your insurance carrier.** Payments can be made to our office by cash, check, Visa, Mastercard or Discover. If your insurance company pays more than expected, you may be reimbursed the difference, or you can elect to have a credit on your child's account.

7. **A signature is needed by a parent or legal guardian to grant Don Cheatham, D.D.S. permission to release any information to third party payers**. You must request and authorize your insurance carrier to directly pay Don Cheatham, D.D.S. for all dental treatment provided for your child.

8. Any co-pay is due on the date of service. This amount is an estimate based as closely as possible on the information that you have given us. We will submit a pre-estimate of dental to your insurance company for all treatment-planned procedures. Keep in mind that treatment may change while waiting for a predetermination response from your insurance carrier. Thus, estimates and costs might change with little notice.

9. Dental insurance is probably the most misunderstood health benefit. We would like to help you and your family understand your dental insurance coverage and utilize the benefits for which it provides. Please feel free to ask any questions you might have.

   I authorize Don Cheatham, D.D.S. to release any information necessary to third party payers and/or health care practitioners regarding my child's dental care. This includes examinations, diagnosis, and records or any treatment.

   I authorize and request my insurance company to pay directly to Don Cheatham D.D.S.

   I understand that my dental insurance carrier may pay less than the actual fees for services provided. I agree to be responsible for payment of all services rendered for my child/children.

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

DATE: _____

NOTICE OF PRIVACY PRACTICES AND PATIENT CONSENT
FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____ DATE: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Children's Dentistry of Coffee Creek may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Children's Dentistry of Coffee Creek has a detailed document called '***Notice of Privacy Practices***'. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the '*Notice*' before signing this agreement. If I ask, Children's Dentistry of Coffee Creek will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the change to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Children's Dentistry of Coffee Creek to use and disclosure my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Children's Dentistry of Coffee Creek has taken action relying on this consent.

Do you authorize any other individuals other than the parent(s) or other legal guardian(s) to act as appointment health care representatives with whom my child's information may be discussed? ☐Yes ☐No

If yes, please enter the name, relationship and phone number of each individual you authorize: _____
_____
_____
_____

SIGNATURE (Patient or Legal Custodian/Authorized Representative): _____

DATE: _____ RELATIONSHIP TO PATIENT (if signed by another party): _____

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our 'Notice' at any time by contacting: Children's Dentistry of Coffee Creek; 2800 N. Kelly Avenue, Suite 200; Edmond, OK; 73003; Phone: 405-562-2222; Fax: 405-562-2200; or by going to www.4kidsdentistry.com/privacy-practices.