HAPPY CAMPERS
pediatric dentistry
— Colton Charles DMD —

Today's Date _____

Child 1 Information: M / F
Name: _____
Pref Name: _____
Birthdate: _____
Address same as Parent/Guardian? YES / NO
Covered under Idaho Smiles program? YES / NO
MID#_____

Child 2 Information: M / F
Name: _____
Pref Name: _____
Birthdate: _____
Address same as Parent/Guardian? YES / NO
Covered under Idaho Smiles program? YES / NO
MID#_____

Child 3 Information: M / F
Name: _____
Pref Name: _____
Birthdate: _____
Address same as Parent/Guardian? YES / NO
Covered under Idaho Smiles program? YES / NO
MID#_____

Child 4 Information: M / F
Name: _____
Pref Name: _____
Birthdate: _____
Address same as Parent/Guardian? YES / NO
Covered under Idaho Smiles program? YES / NO
MID#_____

Child 5 Information: M / F
Name: _____
Pref Name: _____
Birthdate: _____
Address same as Parent/Guardian? YES / NO
Covered under Idaho Smiles program? YES / NO
MID#_____

Mother's Information:
Name: _____
Current Spouse:_____
Birthdate: _____
Cell Phone:_____
Email:_____
Address:_____
City:_____
State:_____Zip:_____
SSN/DL#:_____
Dental Insurance Co:_____
Phone:_____ Group #:_____
Policy #:_____
Primary Policy? YES / NO

Father's Information:
Name:_____
Current Spouse:_____
Birthdate:_____
Cell Phone:_____
Email:_____
Address:_____
City:_____
State:_____Zip:_____
SSN/DL#:_____
Dental Insurance Co:_____
Phone:_____Group #:_____
Policy #:_____
Primary Policy? YES / NO

How did you hear about us?
_____
_____
_____

OFFICE USE:
Initials: _____ Date Entered: _____

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_____ _____
Childs Name **Age**

Medical History

Y N Is your child under the care of a Physician?
Name:_____
Clinic:_____

Y N Has your child had any serious illness?
_____

Y N Been Hospitalized or had any Surgery?
_____

Y N History of heart problems (cardiac defect, surgery, or followed by a cardiologist)?
Y N Need a pre-med for any heart condition?
Y N ADD / ADHD
Y N Asthma, TB or other lung problems
Y N Autism
Y N Cancer, Tumor or Leukemia
Y N Diabetes
Y N Epilepsy / Seizures
Y N Hepatitis or Liver problems
Y N HIV or AIDS
Y N Kidney Disease
Y N Latex or rubber allergy
Y N Sickle Cell Anemia, Hemophilia, Blood disorder
Y N Thyroid Disease
Y N Cerebral Palsy or Developmental Delay
Y N Hearing, vision, or speech problems
Y N Emotional or psychological problems
Y N Any other medical problems or issues?
_____
_____

Y N Is your child allergic to any medication?
_____
_____

Please list any medications your child is taking:
_____
_____
_____

TO BE SIGNED BY PARENT/GUARDIAN IF THE PATIENT IS UNDER 18 YEARS OF AGE

I certify the answers to the medical history questions are accurate and correct to the best of my knowledge. A change in medical condition or medications can affect dental treatment, and I agree to notify the office of any changes.

I authorize Happy Campers Pediatric Dentistry, and associates they may designate, to perform those procedures deemed necessary or advisable to maintain my child's dental health (or minor in my care), including arrangement and/or administration of any sedative (including Nitrous Oxide), analgesic, or other pharmaceutical agent(s), relating to restorative, palliative, therapeutic, and/or surgical treatments.

I understand the administration of local anesthetic may cause bruising, swelling, soreness and/or prolonged numbness. I understand occasionally needles break and may require surgical retrieval.

I do understand, as a part of dental treatment, including preventative procedures such as cleanings, and including restorations of all types, teeth and gums may remain sensitive or painful during and/or after treatment.

I do voluntarily assume any and all possible risks, including serious harm. I understand dentistry deals with multiple biological facets and therefore, reputable practitioners cannot fully guarantee results. I understand behavior dictates treatment options and results, and that no guarantee or assurance has been made regarding dental treatment I have authorized. I acknowledge the nature and purpose of the foregoing procedures have been explained to me and I have been given the opportunity to ask questions.
PLEASE READ BEFORE SIGNING

_____
Print Name of Parent/Guardian

_____
Signature of Parent Guardian Date

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Consent for Use/Disclosure of Health Information
By signing that you have read this, you consent to the use and disclosure of your child's protected health information to carry out any needed treatment, payment activities, and healthcare operations.

Happy Campers Pediatric Dentistry may communicate with you about your child's appointments and dental care via email, text, and phone. Please update said information when there is a change. You have the right to your child's records and we will be happy to release any records with written consent.

You have the right to request we place additional restrictions on the use of and disclosure of your child's healthcare information. We must have legal documentation to fulfill this request.

Our Office Appointment Policy
We require 24 hours' notice when canceling appointments. However, we understand that sick children and emergency situations arise. Please communicate as we do make exceptions for these circumstances. Otherwise, cancellations without 24 hours' notice are subject to a $25 fee to be paid prior to scheduling future appointments. If you are more than 15 minutes late to an appointment, we will need to reschedule and the same fee will apply. If three or more appointments violate this policy within a 12 month period, the family will be subject to dismissal from the practice.

Fees and Financials
It is our mission to provide you with high quality dental treatment that fits your budget, and as a courtesy, we will file claims to your insurance company on your behalf. You will be able to discuss fees and payment prior to your child's treatment so you can be prepared to pay the estimated total at the time of service. This estimate is subject to change because the insurance company will make the final determination of eligibility of benefits. For our uninsured or cash paying patients, we offer a discount. For your convenience, we accept assignment from most insurance plans, as well as payment by cash, check, all major credit cards, and Care Credit.

Concerning financial contracts, our office allows 1 financially responsible party. In case of divorce or separation, the parent authorizing treatment and brining the child to the appointment assumes responsibility. If your account falls delinquent, treatment will be suspended until either the account is brought current or other financial arrangements are made. Without resolving the account, the family could be subject to dismissal.

We reserve the right to report your account status to any credit reporting agency.

We realize temporary financial difficulties may affect timely payment of your account. If such difficulties arise, we urge you to contact us promptly for assistance in the management of your account.

Insurance
We understand necessary dental treatment can sometimes go over the household budget. Therefore, we do our best to ensure having a healthy mouth is affordable. One of the ways you can assist in making that possible is by scheduling routine exams and cleanings. We will do our best to maximize your insurance benefits. We cannot guarantee insurance benefits due to complexities of insurance contracts. Your estimated portion must be paid at the time of service. We acquire insurance eligibility and frequencies as a courtesy to our patients. However, your insurance is a contract between you, your employer, and insurance company. It is ultimately your responsibility to know your contract benefits and inform us of any changes. We will bill insurance companies for services and allow them 45 days to render payment. If payment is not received the patient is responsible for the remaining bill. We will help in every way we can in filing your claim and handling insurance questions.

_____
Print Name of Parent/Guardian

_____
Signature of Parent Guardian Date