SPENCER TASKER D.M.D. **CHRISTIAN PECK D.D.S.**

PATIENT INFORMATION

NAME: LAST_________________________________FIRST_________________________MI_______SEX: M F

ADDRESS ____CITY ______________________________

STATE __________ ZIP _____________ BIRTH DATE: _____/______/_______ AGE: ______

*****APPOINTMENT REMINDERS ARE DONE THROUGH TEXT AND/OR EMAIL*****
IN ORDER TO CANCEL OR RESCHEDULE PLEASE REPLY TO APPOINTMENT REMINDER OR CONTACT OUR OFFICE

CELL __________________________ ____________ EMAIL __________________________ ____________

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

HEAD OF HOUSEHOLD

NAME: LAST_______________________________FIRST_______________________MI_______ SEX: M F

BIRTH DATE: _____/______/______ AGE: ______ SS#_________-______-_______MARITAL STATUS: S M W D

ADDRESS ____CITY ______________________________

STATE ______ZIP _____________ HOME PHONE _______________________WORK ____________________________

CELL _______________________ EMPLOYER____

NUMBER OF YEARS EMPLOYED: ________RELATIONSHIP TO PATIENT_______________________________________

SPOUSE/OTHER PARENT INFORMATION: NAME______________________________EMPLOYER ________________

OCCUPATION_________________________SS# ________-________-__________BIRTH DATE _______/_____/_______

WORK PHONE __________________________ CELL PHONE ______________________________

AUTHORIZED PERSONS ALLOWED TO BRING PATIENT TO APPOINTMENTS OR RECEIVE PATIENT INFORMATION:

____

____

DENTAL HISTORY

NAME OF PREVIOUS DENTIST____

HOW LONG HAS IT BEEN SINCE YOU'VE SEEN A DENTIST? ____________

HAVE YOU HAD ANY PERIODONTAL (GUM) PROBLEMS? YES NO

DO YOUR GUMS BLEED OR FEEL IRRITATED OR TENDER? YES NO

DO YOU FLOSS REGULARLY? YES NO

ARE YOUR TEETH SENSITIVE TO (PLEASE CIRCLE) HOT COLD SWEETS PRESSURE

DATE OF LAST X-RAYS__________________________

DO YOU HAVE HEADACHES, EARACHES, OR NECK PAIN? YES NO

HAVE YOU WORN BRACES ON YOUR TEETH? YES NO

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? YES NO

IF NOT PLEASE EXPLAIN: ________________________________

Medical History

Conditions	Does the patient have any MEDICAL CONDITIONS? ___YES ___NO (For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, ETC)
	If YES, what conditions?
	Does the patient have any HEART conditions? ___YES ___NO (For example: Heart Murmur, congenital Heart Defects, ETC)
	If YES, what conditions?
	Does the patient require an ANTIBIOTIC before being seen? ___YES ___NO If YES, did the patient take the antibiotic? ___YES ___NO
	Does the patient have any history of Cancer or Kidney Disease? ___YES ___NO
	If Yes, please explain:
	Is there any possibility of pregnancy? ___YES ___NO
Allergies	Does the patient have an ALLERGY to LATEX? ___YES ___NO
	Does the patient have any OTHER ALLERGIES? ___YES ___NO (For example: Season Allergies, Animals, Foods, Medications, Nickel, ETC)
	If YES, what allergies?
Medications	Is the patient currently taking ANY Medications/Vitamins? ___YES ___NO
	If Yes, what medications/Vitamins? Why is the patient taking this medication (what condition is it for)?
Dental Concerns	Do you (or the patient) have any DENTAL CONCERNS? ___YES ___NO
	If YES, what concerns do you have?
Surgery	Has the patient had any surgeries/hospitalizations in the past 2 years? ___YES ___NO
	If YES, what was the approximate date and reason?

Emergency Contact:___________________________ Relationship to Patient:_______________________

Phone #:___________________________________

I certify that the information I have given is correct to the best of my knowledge. If any changes do occur I will notify Cabezon Pediatric Dentistry and update my file.

Signature: ____ Date:_________________

Office policies

Welcome to our practice and thank you for choosing us as your dental care providers. We are committed to your treatment being successful. All patients must complete and sign our information/new patient form prior to any treatment. We ask that you please read the following office policies to familiarize yourself with our office. After reading, please sign below. Thank You.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Estimates for major dental care are available. Balances over 90 days are subject to be sent to collections. If sent there will be a 32% service fee applied to the account that must be paid before scheduling any further appointments. There will be a $35.00 handling fee, in addition to any bank charges for any returned checks. For your convenience we accept cash, checks, Visa, Master Card and Discover.

REGARDING INSURANCE

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. Your insurance policy is a contract between you and your insurance company. Although we are happy to assist you with your insurance claims, **we are not a party to that contract**. In the event that we are on contract with your insurance, we require that you pay the deductible (or provide proof that you have done so) and pay the estimated portion of your bill at the time of service. We often accept insurance fee schedules, however **the balance is your responsibility whether your insurance company pays or not. We are unable to bill your insurance company unless you give us your complete insurance information.**

We allow 60 days for your insurance company to pay. **In the event your insurance has not paid within a 60-day period, the bill will then be turned over to you and you will be responsible to pay within the next 30 days**. At that time we also resubmit to your insurance company for the last time. A simple call to your insurance company for you will greatly facilitate the payment. Remember, payment for your dental bill is always your responsibility. We allow your insurance company 60 days to pay as a service to you. All percentages and deductibles are due in full at the time of treatment.

Remember, what we collect from you at the time of visit is only an ESTIMATE. After receiving your insurance payment, we will bill or credit your account the difference.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usually and customary for our area. You are responsible for payments regardless of any insurance company's arbitrary, out-dated determination of usual and customary rates.

APPOINTMENTS AND SCHEDULING

Please remember that once you make an appointment, the doctor's time, treatment room, and support personnel have been reserved specifically for YOU. When we set aside this reserved appointment time for you we will consider it as time you have committed. If you feel that you require a reminder phone call, please request this from our staff. **Unless cancelled at least 24 hours in advance, our policy is to charge $25.00 per regular appointment, or $50 per sedation appointment.** If a missed appointment does occur, we would ask you to pay your missed appointment fee prior to being seen. If a second missed appointment occurs, we ask that you pay your missed appointment fee prior to scheduling your next appointment. If a third missed appointment occurs, we ask that you take the time to find a new dental care provider. When patients fail to arrive for the appointments they scheduled, that time is lost which could have been used to treat other people in need. Please help us serve you better by keeping the appointments you schedule.

Your time is valuable to us. We try to stay on schedule and most of the time we do. We ask that you help us to do this by arriving at least 5 minutes prior to your appointment. **In order to keep our office operating on time, it may be necessary to reschedule your appointment if you are more than 15 minutes late.** If uncontrollable circumstances have occurred to make you up to 15 minutes late, there may be a possibility that you may still be seen. However, other patients that are currently scheduled will be seen first. Despite our best intent, treatment emergencies do, on occasion, arise in our schedule causing unavoidable delays. We will apprise you of any such circumstance at the earliest possible opportunity to avoid any inconvenience for you. Cabezon Pediatric Dentistry communicates via text or email for appointment reminders if you would prefer a different form of communication please inform the front desk.

MINOR PATIENTS

The parent, adult, or guardian accompanying the child during the child's appointment, is responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, payment by case or check at the time of service. All children must be accompanied by their legal guardian. **If an adult that is not the child's legal guardian is bringing in the child, a signed letter by the legal guardian must be presented at the day of appointment or the child will not be able to be seen.**

NITROUS

Please be aware that we use nitrous oxide for all appointments requiring anesthesia. The majority of insurances DO NOT cover Nitrous Oxide. If for any reason you are not wanting to have this administered to your child, please let the office know before the day of the appointment. The parent or guardian bringing the child to the appointment MUST stay in the building the entire length of the appointment.

I HAVE READ THE POLICIES AND I UNDERSTAND AND AGREE TO THEM

______________________	______________________	______________________
NAME (PLEASE PRINT)	SIGNATURE OF PATIENT OR RESPONSIBLE PARTY	DATE

Cabezon Pediatric Dentistry
2421 Cabezon Blvd. SE
Rio Rancho, NM 87124
Ph: 505.884.5437 – Fax: 505.994-2146

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 Cabezon Pediatric Dentistry 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 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.

Cabezon Pediatric Dentistry has a detailed document called the '***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, Cabezon Pediatric Dentistry will provide me with the most current *Notice of Privacy Practices.*

My Signature below indicates that I have been given the chance to review such a copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Cabezon Pediatric Dentistry to use and disclose 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 Cabezon Pediatric Dentistry has taken action relying on this consent.

____ ____________________

SIGNATURE (Patient or Legal Custodian/Authorized Representative) **DATE**

____ ____________________

Relationship to Patient (if signed by another party) **DATE**

You may obtain a copy of our *Notice of Privacy Practices,* including any revisions of our *'Notice"* at any time by contacting: Cabezon Pediatric Dentistry • 2421 Cabezon Blvd. SE • Rio Rancho, NM 87124 • 505-884-5437

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HIPAA Compliance Program

Cabezon Pediatric Dentistry
Dr. Spencer Tasker • Dr. Christian Peck

Request and Consent for Pediatric Dental Treatment

Please read this form carefully! If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it!

1. I request and authorize the treatment and procedures (i.e. exam, x-rays, and / or cleaning) outlined on the PLAN OF CARE for: Patient Name: ____

2. I further request and authorize the taking of oral dental x-rays and the use of such anesthetics as may be considered necessary to treat the patient's dental problem(s)

3. The usual and most frequent risks or complications occurring from the planned treatment and procedures also have been explained to me. These risks include, but are not limited to the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

4. I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's plan of care and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledges that no guarantees have been made to me concerning the results of the dental treatment that the patient receives at Cabezon Pediatric Dentistry.

5. I understand that treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

6. I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and /or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and / or parent to hold the patient's hands, stabilize the head and / or control leg movements. At this time, you have the option of stopping treatment and discussing stronger sedation options such as oral sedation, deep sedation, or general anesthesia.

7. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational, or research purposes.

8. All of my questions have been answered to my satisfaction and consent to the treatment and procedures prescribed for the patient on the plan of care.

9. I confirm that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

____ ______________________

Signature of Person Consenting to Treatment Date

____ ______________________

Signature of Doctor Date