Cherry Creek Pediatric Dentistry, Prof., L.L.C.
David Hayutin, D.D.S., Prof., L.L.C.
5055 E. Kentucky Avenue • Denver, CO 80246 • 303-757-8844

Today's Date _____

PATIENT REGISTRATION FORM

We not only care about your dental health, but also your total well-being. Please take the time to answer all of the following questions carefully. In doing so, it will enable us to serve you better.

Patient Full Name_____ Nickname _____

Home Address _____City_____State_____Zip_____

Home Phone _____ Patient Birthdate_____ Sex_____

Patient Social Security Number _____

Mother's Name: _____

Employed By: _____ Work Phone _____

Social Security Number: _____ Birthday: _____

Father's Name: _____

Employed By: _____ Work Phone_____

Social Security Number: _____Birthday:_____

If Insured Please Fill Out This Portion:
Employee Name: _____ Group #: _____

Insurance Co. _____ Ins Phone _____

Insurance Address _____

Second Insurance Co. _____

Please have your insurance form filled out completely, accurately and signed. We also have some general ADA forms for your convenience if you did not bring one of yours. It is your responsibility to obtain necessary pre-approval forms prior to coming if required by your insurance company. If you have come to the visit without proper insurance company pre-authorization or eligibility, you are liable for the charges for incurred those visits. Thank you.

Patient's Physician _____ Phone_____

Address _____ City _____ State _____ Zip _____

Reason For This Visit _____

We always welcome new patients!! Who may we thank for your referral to us? _____

Patient's closest relative/friend, other than a parent: _____

Their relationship: _____ their phone: _____

Payment is expected at the time of service unless previous written arrangements were made in advance. I understand I am fully liable for all charges incurred at the office.

X_____
Signature of parent/legal guardian

Please Check The Following And Provide A Brief Description When Necessary. Thank You.

1. General state of health ____ Excellent ____ Good ____ Fair ____ Poor
2. Under a physician's care within the last 6 months? ____ Yes ____ No _____
3. Taking any drugs or medications? ____ Yes ____ No _____
4. Serious illness or hospitalizations? ____ Yes ____ No _____
5. Exceptional or handicapped? ____ Yes ____ No _____
6. General allergies or allergies to drugs, penicillin or anesthestics? ____ Yes ____ No _____
7. Hepatitis or Jaundice? ____ Yes ____ No _____
8. Heart Disease, HEART MURMUR, Rheumatic fever? ____ Yes ____ No _____
9. Respiratory problems or asthma? ____ Yes ____ No _____
10. Frequent colds, sore throats or sinus trouble? ____ Yes ____ No _____
11. Bleeding disorders or prolonged bleeding? ____ Yes ____ No _____
12. Radiation (xrays) or chemotherapy? ____ Yes ____ No _____
13. Convulsions or seizures? ____ Yes ____ No _____
14. Nervous system disorder? ____ Yes ____ No _____
15. History of psychological or psychiatric problems? ____ Yes ____ No _____
16. Endocrine, gastrointestinal, kidney, bladder, genitourinary, hair, skin or bone problems? ____ Yes ____ No _____
17. Diabetes? ____ Yes ____ No _____
18. AIDS or HIV Positive? ____ Yes ____ No _____
19. Venereal Diseases? ____ Yes ____ No _____
20. For female patients -- pregnant or trying to get pregnant? ____ Yes ____ No _____
21. Family history of tubercluosis, diabetes, bleeding, AIDS or other inheritable diseases? ____ Yes ____ No _____
22. Immunizations up to date? ____ Yes ____ No _____
23. Date of last dental visit _____ Previous dentist seen _____
24. Problems with previous dental visits? ____ Yes ____ No _____

I hereby certify to the acccuracy of the above health history.

X_____ _____
Signature of parent/legal guardian Date

UPDATES FOR OFFICE USE:

_____ _____

_____ _____

_____ _____

_____ _____

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INFORMED CONSENT FOR DENTAL TREATMENT

Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks and benefits from the chosen procedures versus the alternatives and its risks and benefits. It is our intent that all professional care delivered in our dental practice shall be of the best possible quality we can provide for each child. To facilitate your child's care, please read the following.

1. Authorization is hereby granted to the dentist to treat any dental illness, injury or other condition(s) of this patient using some/all of the following, but not limited to, all necessary dental treatment and materials, oral surgery, including the use of local anesthetics, radiographs (xrays), diagnostics aids, prophylaxis (cleanings), fluoride treatments, and nitrous oxide (laughing gas).

2. Before scheduling or proceeding, the dental conditions have been or will be explained to me to my satisfaction. Possible alternate methods along with potential complications and risks of treatments and their alternatives have been or will be explained to me. My questions have been or will be answered to my satisfaction.

3. If such a procedure necessitates the removal of a tooth or tissue, I understand it will be given to the patient or the proper recipient.

4. I understand that dentistry is not an exact science and that NO GUARANTEES have been made by the dentist relating to the result of the dentistry authorized.

5. It has been or will be explained that the patient's dentist, the dentist, will be responsible for the performance of the proposed procedures described above. I also understand that if the services of dental assistants and other personnel are required, I also authorize such personnel to provide service and care. I am satisfied that I understand, to the best of my ability, the nature of the illness and the treatments or procedures as stated above and hereby give my consent.

6. I also give consent to the release of dental records, information and other information to my insurance carrier. I also authorize my insurance carrier to forward any benefits otherwise payable to me directly to the dentist through photographic, handwritten or computer generated "signature on file" modes which shall be valid as the original signed form by the insured employee.

7. I also consent to the exchange of information, including visual records, between other dentists and/or agents when such information will benefit the patient or be of value in patient education or research.

8. I have read and understood the attached patient management and behavior techniques sheet. I consent to the use of these behavior management techniques when necessary for the health and well being of the patient. A copy will be provided upon request.

9. I understand this consent will be in effect until such time as I revoke or terminate it through written notification.

10. Due to the number of children who require the services of a specialist, we have found it necesary to institute a policy regarding our appointments, thus I understand that if three (3) appointments PER FAMILY are short cancelled (less than 48 hours notice) or not shown up to, the FAMILY may be referred to another practitioner for care. SHORT CANCELLATION FEES may be charged at $50 per half hour per patient for appointments missed which must be paid before being rescheduled.

NOTE: Payment is due when services are rendered. IF our office pre-approves in WRITING monthly payments, they are due by the due date on the statement. Rebilling fees ($5) are placed monthly on accounts with balances. If there is no personal payment by the due date, a $25 late/past due service charge is assessed. Service charges are not reversible. All delinquencies (over 30 days) are subject to outside collections. If outside collection is necessary, I agree that I will be responsible for paying the fees charged to the office by any collection agent (collection costs) and bank fees, such as, returned check fees ($25). I further understand that I may be liable for attorney fees along with any additional court costs awarded by the court. I further understand that I MAY be charged up to the legally allowed interest per anum and/or, but not simultaneously with monthly rebilling fees of $5 (monthly payment fee) and $25 (late fee) per month for balances over 20 days old. Future appointments may be postponed WITHOUT NOTICE until the account has a zero balance. Collection accounts are not permitted re-entry into the practice.

X _____ _____

Signature of parent/legal guardian | Date

X _____ _____

Patient Name | Office Name

PATIENT BEHAVIOR AND MANAGEMENT TECHNIQUES

Providing high quality care, can sometimes be made difficult, even impossible, because of the lack of co-operation of some patients. Among behaviors that can interfere with proper dental care are hyperactivity, resistive movements, refusing to open mouth or to keep it open long enough to perform the necessary dental treatment, and even aggresive or physical resistance to treatment, such as kicking, biting, screaming and grabbing the dentist's hands or his sharp instruments.

All efforts are made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding. There are several behavior management techniques that used by pediatric dentists to gain the cooperation of child patients and to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. Our more frequently used pedicatric dentistry behavior management techniques are listed below.

1. TELL-SHOW-DO: The dentist or assistant explains to the child what will be done using simple terminology and repetiton and then shows the child what will be done by demonstrating with the instruments on a model, the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce the cooperative behavior.

2. POSITIVE REINFORCEMENT: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or prize.

3. VOICE CONTROL: The attention of the disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.

4. MOUTH PROPS: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.

5. HAND-OVER-MOUTH EXERCISE: The disruptive screaming child is told that a hand will be placed over the child's mouth. When the hand is in place, the dentist speaks directly into the child's ear and tells the child that if the noise stops the hand will be removed. Whe the noise stops, the hand is removed and the child is praised for cooperating. If the noise resumes, the hand is again placed on the mouth and the exercise repeated as needed.

6. PHYSICAL RESTRAINT BY THE DENTIST: The dentist restrains the child from movement by holding the child's hands or upper body, stabilizing the child's head between the dentist's arm and body, or positioning the child firmly in the dental chair.

7. PHYSICAL RESTRAINT BY THE ASSISTANT: The assistant restrains the child from movement by holding the child's hands, stabilizing the head, and/or controlling leg movements.

8. PAPOOSE BOARDS AND PEDI-WRAPS: These are restraining devices for limiting the disruptive child's movements in order to prevent injury and to enable the dentist to provide the necessary treatment. The child is wrapped in these devices and placed in a reclined chair. Your consent is gained before using the wraps.

9. SEDATION: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate with the dental procedures. These drugs may be administered orally, by injection or by a gas. The child does not become unconscious. Your child will not be sedated without your being further informed and obtaining specific consent for such procedures.

10. GENERAL ANESTHESIA: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given general anesthesia without your being further informed and obtaining your specific consent for such procedures.

PLEASE DO NOT REMOVE THIS SHEET

WE WILL BE HAPPY TO PROVIDE COPIES OF THIS AND OTHER PAGES FOR YOU UPON REQUEST

DISCLOSURE OF HEALTH INFORMATION PURSUANT TO NOTICE OF PRIVACY PRACTICES

You have the right to read our Notice of Privacy Practices (hereinafter "Notice") before you decide whether to sign this consent. Please read it carefully and completely before signing this consent. The Notice describes our treatment, payment activities and heathcare operations.

PURPOSE: By signing this form, you have consented to our use and disclosure of your protected heath information to carry out treatment, payment activities and healthcare operations. Full discussion of these topics is available in our new patient packet which you read, completed and signed at your first visit.

We reserve the right to change our privacy practices as described in our Notice and this consent shall remain valid for any future changes until revoked. You have the right to revoke this consent by written notification which begins the revocation on the date it is signed. We will refuse to treat the family from that date forward.

A personal copy of our Notice of Privacy Practices is available from our privacy contact person: David Hayutin, D.D.S. at 5055 E. Kentucky Avenue, Denver, CO 80246, 303-757-8844 during regular business hours.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION AND ACKNOWLEDGMENT OF READING THE NOTICE

I, (parent, legal guardian name)_____
of (minor child name)_____, have had full opportunity to read and consider the Notice contents.

My signature below ACKNOWLEDGES that I have read a copy of the Notice of Privacy Practices for the office.

My signature below gives my CONSENT for the office to use and disclose the family's protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date_____