Oreskovich
DENTAL · CLINIC

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Pueblo CO 81005
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We know you have many choices when it comes to choosing a dentist. At Oreskovich Dental Clinic, we make it a priority to provide a comfortable dental experience that's tailored to your needs. We want to make it as easy as possible for you and your family to get the dental care needed for healthy smiles. Not everyone has dental insurance, and our office has always been happy to work with patients with/without dental insurance. We will be happy to work with you to find a solution that works best for you.

Insurance is a great incentive to maintain a vital level of dental health. Some insurance companies pay 100% of preventative services (cleanings, x-rays, & exams). It is rare--very rare--that anything other than preventative is paid at 100%. Please keep in mind, you are responsible for your total charges should your insurance benefits result in less coverage than anticipated.

We will do our best to answer any insurance questions you may have, and will be happy to request a predetermination of benefits to let you know what your insurer will pay. Please remember, your insurer dictates your coverage--we do not.

For those patients that have discount fee-for-service dental plans, such as Alpha Beta Dental Plan of Colorado or Assurant Employee Benefits Plan, all discounted dental fees are due in full at the time of service.

PATIENT RESPONSIBILITY & ASSIGNMENT OF BENEFITS

I, _____hereby irrevocably assign all dental benefits for services performed by Oreskovich Dental Clinic to include major dental benefits to which I am entitled. This includes Medicare and other government sponsored programs, private insurance and any other health plan.

I understand that I am financially responsible for all charges, whether or not paid by said insurance. Failure to meet this obligation may result in referral for collection. If my account is assigned for collection, I will be responsible for collection fees of 50% court costs, and reasonable attorney fees, together with interest at 18% per annum.

I hereby authorize said assignee to release all information necessary to secure payment of said benefits.

Signature:_____Date_____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

*Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
*Obtain payment from third-party payers
*Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this office at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____Relationship to Patient:_____

Signature:_____Date:_____

APPOINTMENT CONFIRMATION & CANCELLATION POLICY

Appointments and time are valuable to everyone. To remind you about an upcoming visit, we can notify you by the following methods. Check as many as you would like.

- Call this number_____
- Text this number_____
- Email this address_____

When we schedule an appointment, that time has been set aside for you. We understand that unexpected emergencies or even a forgotten appointment do happen. If you can't make your appointment, please notify us within 48 hours of scheduled time. A fee of $50.00 may be applied for missing an appointment. We promise to be understanding if a valid reason is given for missing your appointment. A $50.00 fee WILL be charged to your account for all NO SHOW/NO CALL appointments. Repeated missed appointments will result in dismissal of patient status.

Signature:_____Date:_____

WELCOME

1 About Your Child

Today's Date: ____ /____ /____ File #:_____

Child's Name: _____
LAST FIRST M.I.

Child's Nickname: _____ ❑ Boy ❑ Girl

Child's Birthdate:____ /____ /____ Age:_____

School:_____ Grade: _____

Child's Home Phone #:(_____) _____

Child's SS#: _____

Child's Address: _____
HOME ADDRESS

_____
CITY STATE ZIP

Referred By: _____
(If doctor, please give address & phone number.)

_____

2 Insurance Information

Primary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___ /___ /___

Insured's Employer: _____

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: _____

Insured's ID#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ___ /___ /___

Insured's Employer: _____

3 Child's Family Information

Who is accompanying this child today?

_____ _____
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters?_____ Age(s): _____ _____ _____

Mother's Name: _____
❑ STEP MOTHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____) _____ (_____) _____ _____
HOME PHONE # WORK PHONE # EXT.

_____ _____/_____/_____ _____
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: _____ How Long?_____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: _____
❑ STEP FATHER ❑ GUARDIAN

_____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(_____) _____ (_____) _____ _____
HOME PHONE # WORK PHONE # EXT.

_____ _____/_____/_____ _____
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: _____ How Long?_____

_____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: _____ _____
RELATION TO CHILD

Billing Address: _____

_____
CITY STATE ZIP

_____ _____/_____/_____ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(_____) _____ _____ (_____) _____
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ❑ Cash ❑ Check

_____ /_____
❑ Credit Card - Enter card # above (if accepted)

_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Is Child in pain? ❑ No ❑ Yes How Long?_____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth ❑ Loose tooth
❑ Other(s): _____

Does child require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: _____ (_____) _____

Last Dental exam: ____ /____ /____ Last Dental X-rays: ____ /____ /____

Times a day child brushes? _____ Times a week child flosses? _____

Is the child's water fluoridated? ❑ Yes ❑ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ❑ Pain killers (INCLUDING ASPIRIN) ❑ Ritalin ❑ Stimulants
❑ Blood Thinners ❑ Tranquilizers ❑ Insulin ❑ Muscle relaxers ❑ Others:_____

Child's Physician:_____ (_____) _____
DOCTOR'S NAME OR CLINIC NAME PHONE#

_____ Last Medical Exam:____ /____ /____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or ever had: _____

_____

Is Child allergic to: ❑ Latex ❑ Penicillin/Amoxicillin ❑ Tetracycline ❑ Dental Anesthetics (Novocaine)
❑ Aspirin ❑ Food allergies ❑ Other(s):_____

Please rate the child's general health from 1-10:_____ Does child wear contact lenses? ❑Yes ❑No

Has this child ever taken the drug Ritalin? ❑ No ❑ Yes/How long?_____ Child's Blood type:_____

Does this child do any of the following? ❑ Thumb/Finger Sucking ❑ Tongue Thrusting/Sucking
❑ Heavy Snoring ❑ Mouth Breathing ❑ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____ / ____ / ____
❑ Parent or Guardian ❑ Other:

UPDATE (OFFICE USE)

Initials / / Date

Comments

Initials / / Date

Comments

Initials / / Date

Comments