CERVEN
DENTISTRY

405 S. Granite Ave.
PO Box 959
Granite Falls, WA 98252
tel (360) 691-7793 fax (360) 691-5577
www.CervenDentistry.com

To help us better serve the needs of your child and meet his/her dental healthcare needs, please complete the following form. If you have any questions or need assistance, please ask us - we are happy to help!

Your Child

Child's Name _____
Wishes to be called _____ Sex ❑ F ❑ M
DOB _____ Age _____
Child's Home Address _____
City _____ State/Zip _____
Phone _____

Person Responsible for Scheduling?

Name _____
Relationship to patient _____

How can we best reach you?

❑ Cell ❑ Email _____
❑ Work ❑ Home

Time of Day _____

Mother

❑ Stepmother ❑ Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. # _____
E-Mail _____
Employer _____ Occupation _____
SS# _____ DOB _____

Marital Status

❑ Single ❑ Married ❑ Other _____

Father

❑ Stepfather ❑ Guardian

Name _____
Home Phone _____ Cell Phone _____
Work Phone _____ Ext. # _____
E-Mail _____
Employer _____ Occupation _____
SS# _____ DOB _____

Marital Status

❑ Single ❑ Married ❑ Other _____

Responsible Party Other Than Listed

Name _____
Relationship to patient _____
DOB _____ Soc. Sec. # _____
Address _____
City _____ State/Zip _____
Employer _____ Occupation _____
Work Phone _____ Ext. # _____
Home Phone _____ Cell Phone _____

Emergency Contact

Name _____
Phone Number _____
Relation to patient _____

Dental Insurance Information

Primary Insurance

Name of Insured _____
Relationship to Patient _____
Insured's DOB _____
Insurance ID. # _____
Employer _____
Occupation _____
Insurance Company _____
Group# _____
Ins. Co. Address _____
Ins. Co. Phone _____

Secondary Insurance

Name of Insured _____
Relationship to Patient _____
Insured's DOB _____
Insurance ID. # _____
Employer _____
Occupation _____
Insurance Company _____
Group# _____
Ins. Co. Address _____
Ins. Co. Phone _____

Authorization and Release

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____

Signature of parent/guardian Date

Thank you for filling out this form completely. The information you have provided will help us serve your child's dental healthcare needs more effectively and efficiently.

Name _____

HEALTH HISTORY

Is your child having any pain or discomfort at this time? ❑ Yes ❑ No

Has your child been hospitalized during the past 2 years? ❑ Yes ❑ No

Has your child been under the care of a medical doctor during the past 2 years? ❑ Yes ❑ No

Physician Name _____

Address _____ Phone: _____

Is your child currently taking or has your child taken any medications in the past two years? ❑ Yes ❑ No

If yes, please list and reason for: _____

_____

_____

Please list any serious medical condition(s) that your child has or has had: _____

_____

_____

Please check "Yes or No" to the following conditions:

Y	N		Y	N		Y	N		Y	N	
❑	❑	High / Low Blood Pressure	❑	❑	Liver Disease / Yellow Jaundice	❑	❑	Fever Blisters / Cold Sores	❑	❑	Developmental Delay
❑	❑	Congenital Heart Defect	❑	❑	Kidney Failure/Disfunction	❑	❑	Fainting / Dizzy Spells	❑	❑	Psychiatric Problem
❑	❑	Heart Murmur / Rheumatic Fever	❑	❑	Thyroid Disease	❑	❑	Epilepsy / Seizures			
❑	❑	Heart Surgery	❑	❑	Frequent Stomach Upset/Aches	❑	❑	Hay Fever / Sinus Trouble			Other
❑	❑	Diabetes	❑	❑	Chemotherapy / Cancer	❑	❑	Allergies / Hives			_____
❑	❑	Blood Transfusion / Anemia	❑	❑	Asthma	❑	❑	Nervousness			_____
❑	❑	Sickle Cell Disease	❑	❑	Cough / Tuberculosis (TB)	❑	❑	Psychiatric Treatment			_____
❑	❑	Bruise Easily	❑	❑	A.I.D.S. / H.I.V.	❑	❑	Drug / Alcohol Addiction			_____
❑	❑	Hemophilia	❑	❑	Hepatitis: A B C **(circle one)**	❑	❑	Speech Delay			
❑	❑	Frequent Headaches	❑	❑	Pain in Jaw Joint	❑	❑	Hearing Difficulty			

Is your child allergic to or reacted adversely to any of the following?

❑ Antibiotics ❑ Aspirin

❑ Codeine ❑ Latex

❑ Metals/Jewelry ❑ Local/Dental Anesthetic

Does your child have allergies to any other medications or substances? If yes, please list:

_____

_____

_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Cerven and/or dental staff to perform the necessary dental services my child may need.

Parent/Guardian Signature _____ Date ____/____/____

OFFICE FINANCIAL POLICY

Stacey Cerven DMD PS

Insurance

If you have dental insurance, we will make a ***good faith estimate*** of the amount your insurance carrier may pay based on the information provided to us. As the insured, it is your responsibility to determine the coverage by your insurance for any dental services provided in our office. As a courtesy, we will file all dental claims on your behalf as well as provide any information required by your insurance carrier to ensure it is processed in a timely manner.

If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. All questions regarding your insurance benefits must be addressed to your insurance carrier. _____

please initial

Payment

The amount estimated to be your portion of treatment, is due at the time dental treatment is provided. To make this possible, we offer the following payment options:

- Cash/Check
- Visa, MasterCard, or Discover
- Debit cards (that bear the Visa or MasterCard logo)
- Care Credit

Patient Responsibility, Assignment and Release

I acknowledge my responsibility for the total payment of all services performed in this office in accordance with their regular fees and terms.

I understand my responsibility is not modified by whether any third party (insurance) pays for all, part, or none of the charges. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered.

I understand that my account becomes *delinquent if not paid within sixty (60) days after billing* and that at that time a finance charge of 1.0% of the unpaid balance will be charged every month until the balance is paid in full (RCW 19.52.020).

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical/dental care information requested by my insurance carrier.

We are here to assist you in any way possible. Please make your questions and concerns known to our team … Our goal is to ensure that you have an outstanding experience.

Patient Name (printed): _____

Signature (responsible party): _____ Date: _____

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Statement of Privacy Practices

Cerven Dentistry

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

Protecting your Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Healthcare Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Healthcare Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Cerven Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Cerven Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	**☐ YES**	**☐ NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	**☐ YES**	**☐ NO**
Any Member of my extended family: (Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other: _____	**☐ YES**	**☐ NO**
Name of patient (please print): _____		
Patient signature:_____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature:_____		
Representative's Telephone Number: _____Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:_____**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

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