1. Tell Us About Your Child

Child's Name

____

Last First Date of Birth

Siblings:

____

Last First Date of Birth

____

Last First Date of Birth

____

Last First Date of Birth

Child's Main Phone #____________________________

Child's Home Address____________________________

____

City State ZIP Code

2. Mother's Information

Name:____

Mother____ Stepmother____ Guardian____

Date of Birth:___/___/____

Employer_______________________________________

Work #____

Home #____

Cell Phone #____________________________________

SS#____

Email____

3. Father's Information

Name:____

Father____ Stepfather____ Guardian____

Date of Birth:___/___/____

Employer_______________________________________

Work#____

Home #____

Cell phone#_____________________________________

SS#____

Email____

Do mother and father live together? Yes__ No__

4. Who is Accompanying the Child Today?

Name____

Relationship____________________________________

Do you have legal custody of this child? Yes No

5. Primary Dental Insurance

Insurance Co. Name______________________________

Insurance Co. Address____________________________

____

Insurance Co Phone #_____________________________

Group #____

Member ID______________________________________

Subscribers Name________________________________

Relationship to Patient___________________________

Subscriber's Date of Birth:___/____/_____

Subscriber's SSN_________________________________

Subscriber's Employer____________________________

6. Do you have secondary dental insurance?

No___ Yes___

If yes, you will be asked to provide us with this additional information.

We are happy to file your insurance claims as a courtesy to you. Thank you for providing accurate and updated information as it will expedite timeliness on your account.

Revised 8/2021

GREGORY D. EVANS, DDS PC AND RACHEL ECKER, DMD
3221 Eastbrook Drive; Fort Collins, CO 80525 ~ Phone: (970) 407-1020 Fax: (970) 266-8238

HEALTH HISTORY

We believe that to best serve your child's dental health, we must understand your child in the larger context of his/her social and medical history. Please help us by thoughtfully answering the following questions. Please note that all health histories are held in strict confidence among our team. Complete both pages of the form.

______________________________ M / F ________________ ______________ ________
Child's Name (Last, First) Child's Nickname Date of Birth Weight

__________________________________ __________________________
Child's Home Address Phone Number

Child's Physician _________________________Phone_____________ Family Dentist_________________________
Physician's Address____

Is the child under care for any medical conditions? (Y / N) Medical diagnosis? ______________________________
Immunizations up to date? (Y / N / Unsure) Medication taken by child? _____________________________________
Has child ever spent the night in a hospital? Explain:____

Allergies: Latex (Y / N) Metal (Y / N) Foods: ____
Medications: ____
Reaction to above allergies: ____

Has your child ever had or been diagnosed with any of the following:

(Y) (N)
___ ___ Anemia
___ ___ Blood Disease
___ ___ Blood Transfusions
___ ___ Bruises Easily
___ ___ Hemophilia
___ ___ Sickle Cell Trait or Disease

(Y) (N)
___ ___ Aids/HIV
___ ___ Cancer or Malignancy
___ ___ Chronic Illness
___ ___ Diabetes
___ ___ Epilepsy
___ ___ Hepatitis/Liver disease
___ ___ Kidney Disease
___ ___ Transplant_____________

(Y) (N)
___ ___ Asthma
___ ___ Respiratory Problems
Disease/RSV
___ ___ Heart Surgery
___ ___ Heart Murmur/Defect
___ ___ High Blood Pressure
___ ___ Rheumatic Fever

(Y) (N)
___ ___ Birth Defects
___ ___ Child Abuse
___ ___ Concussion
___ ___ Growth Problems
___ ___ Premature Birth
___ ___ Surgery _______________
___ ___ Syndrome ________________

(Y) (N)
___ ___ Arthritis
___ ___ Bone/Joint Problem TMJ
___ ___ Headaches
___ ___ Metabolic Disorder
___ ___ Muscle Disorder

(Y) (N)
___ ___ Brain Injury
___ ___ Developmental Delays
___ ___ Hearing and/or Speech Problems
___ ___ Hyperactivity/ADD/ADHD
___ ___ Neurological Disorder

Dentist's Notes

HEALTH HISTORY REVIEWED
- No Concerns
- Medical Alert
- Allergy
____
- PreMed
____
- Call MD
____

Doctor's Initials ______

Are there any other conditions we need to know?____

Has your child ever had traumatic injury to the head?____

Has your child ever had traumatic injury to the teeth?____

Health History – Page 2

Please answer based upon your child's age**:**

1. Feeding History (ages 0 – 2.5 years):
   My child was: ___breast fed ___bottle fed ___combination
   Bottle introduced at age: _____
   Bottle Use: ___currently used ___discontinued (At what age? ____)

2. Oral Hygiene (ages 0 – 9 years):
   Have your ever received instruction on how to clean your child's teeth? ___yes, ___no
   My child brushes ____times a day. An adult (___supervises, ___helps, ___brushes, ___none) per day.
   My child has their teeth flossed (___ every day, ___occasionally, ___not currently).

3. Fluoride Use (all ages):
   When did your child begin to use toothpaste? ____________ How often / day? _____________
   Who applies the toothpaste to the brush? ___child, ___adult
   My child (___does, ___did, ___did not) receive supplemental fluoride drops or tablets.
   Our primary water supply (___does, ___does not, ___unsure) contain fluoride.

4. Habits (all ages):
   My child (___does, ___ does not) suck a (___ thumb, ___ finger, ___pacifier).
   When, where and how often? _____________________________Stopped at age: _____________

5. Dental History (all ages):
   Is there any history in your family of any:
   ___malocclusions (bad bites), ___missing teeth, ___extra teeth, ___other(explain__________________

   Do you think there is anything wrong with your child's teeth? __________________________________
   Has your child ever had a ___space maintainer, ___retainer, ___braces, ____ or any other orthodontic treatment? (Explain: ____)
   What is the primary reason for today's visit? ____

6. Family History (all ages):
   Do mother and father live together? ___yes, ___no
   Is your child adopted? ___yes, ___no If yes, when? _______________________
   Please explain any recent family status changes (divorce, separation, death, etc.), and note when your child experienced this change: ____
   Is your child receiving any therapy or extra help in any area? _________________________________

7. Referral (all ages):
   How did you hear about our office? (List name or media responsible for referral): ___________________

CONSENT

Treatment Consent - It is necessary, because your child is a minor, for permission to be obtained from a parent/ legal guardian before necessary treatment is performed. The signature of the parent/guardian below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment, regardless of insurance coverage.

Signed: ____ Date: ________________________

Records release for diagnosis purposes and referral purposes.

The undersigned consents to the use of agreed upon x-rays and clinical photographs. It is my understanding that Big Grins may need to share the above information with other offices for diagnosis or referral purposes. I fully understand this consent and have no further questions.

Signed: ____ Date: ________________________

DR. GREGORY D. EVANS, DDS PC & DR. RACHEL ECKER, DMD

Treatment Consent- It is necessary, because your child is a minor, for permission to be obtained from a parent/legal guardian before necessary treatment is performed. The signature of the parent/guardian below authorizes the completion of all agreed upon dental treatment and the use, of those methods appropriate thereto. This consent shall remain in full force and effect until cancelled by either party. Signature ____________________

Financial Agreement- We find that our clients appreciate knowing in advance what is expected of them financially and what terms and conditions are available. If you have any questions, please direct them to one of our Financial Administrators. As a courtesy to you, we will submit your claim for you if you have insurance. Your insurance policy is an agreement between you and your insurance company. Our relationship is with you, not your insurance company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. You are responsible for the total charges or any difference remaining following payment by your insurance company. We will estimate as closely as possible your coverage. If your insurance has not made payment or you feel that your insurance company has not made adequate payment on your account, you must contact them first to discuss this matter.

__________ (initial)

Your insurance company is required by the Colorado Insurance Commissioner to process, pay or reject all insurance claims within 30 days. We guarantee accurate filing based on the information that you provide to us. On day 31, if your insurance company has not reimbursed our office, we will investigate the delay as a courtesy. If needed, we will resubmit your insurance claim one tim for you. We will notify you of your insurance company response and the responsibility of the balance will revert to you.

__________ (initial)

Payment is expected on date of service. We gladly accept cash, personal checks, a1nd most major credit cards for payment of your account. For your convenience, we also work with Care Credit. We will try to accurately estimate your patient portion which is due after insurance. As a courtesy, we would be happy to send a pre-determination to assist with accurate patient portions. In different circumstances, if the patient portion was not collected on date of service, payment is expected within 30 days of insurance payment. We will send you a statement, and payment is due upon receipt. We will begin to charge a late fee of $5.00 per month on accounts that have remaining balances over 90 days. For your convenience you may now pay your bill online at gobiggrins.com and click on "Payment Portal".

Best way to receive statements _text _mail Signature ________________________________

Records release for diagnostic and referral purposes-The undersigned consents to the use of agreed upon x-rays and clinical photographs. It is my understanding that Big Grins may need to share the above information with other offices for diagnosis or referral purposes. I fully understand this consent and have no further questions.

Signature ________________________________

Big Grins is proud to be an on time dental practice. We trust that you will arrive oh time for that appointment. If you are more than 5 minutes late to your appointment, we will then evaluate if we will still be able to keep the appointment upon your arrival. If the schedule allows we will try our best to keep the appointment. However, please note that we may need to reschedule your reserved time in order to stay on time for our other patients. (NOTE: If we do have to reschedule because the schedule will not allow us to see your child that day, it could be a few weeks out before we ill be able to reschedule them.)

__________ (initial)

We reserve this time specifically for you and your child as we do the same for all our patients and it helps to respect everyone's time by staying on time. We try our best to do so and ask for your help and consideration. Of course, we also strive to be as flexible as possible because we have kids too.

Reminders- We do our part by sending you appointment reminders. We send out 3 appointment reminders, 3 weeks, 1 week, and 72 hours out. We do this to help you manage this reserved time and it will also help prevent you from being charged. The 72 hour notice will allow 24 hours to decide if you need to cancel without getting charged the late fee.

Cancellation/No Show Fee- If you do need to cancel your appointment, we do request a 48 hour cancellation notice. This will allow us the appropriate time to fill your appointmen1t and to try to get other patients in that are on a waiting list. IF you cancel within the 48 hour prior to your appointment you will be charged a $35.00 late cancellation fee. (This fee will be axed out at $50.00 per family.) If you no show/no call you will be charged a $35.00 no show/no call fee.

__________ (initial)

In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services; and I agree to pay all legal costs including collection fees and attorney fees if I fail to pay my account. I also agree to pay any additional fees noted above. I grant you, or your assigned, to telephone me at home or at my work to discuss matters related to this form. I have read and agree to the above conditions of treatment.

Signature ______________________________ Date _______________________

____
PLEASE PRINT name of Parent/Guardian

____
Patient's Name

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Notice of Patient Health Insurance Portability and Accountability Act (HIPAA)

Patient Name:___________________________Date of Birth: __________________

I have read or had the opportunity to read practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- **A statement that this practice is required by law to maintain the privacy of protected health information.**
- **A statement that this practice is required to abide by the terms of the notice currently in effect.**
- **Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.**
- **A description of each of the other purposes for which this practices I permitted or required.**
- **A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.**
- **My individual rights with respect to protect health information and a brief description of how I may exercise these rights in relation to:**

  ► **The right to complain to this practice and the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.**
  ► **The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.**
  ► **The right to receive confidential communications of protected health information.**
  ► **The right to inspect and copy protected health information.**
  ► **The right to amend protected health information.**
  ► **The right to receive an accounting of disclosures of protected health information.**
  ► **The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.**

This practice reserves all rights to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

SIGNATURE________________________________ DATE________________

Relationship to patient (if signed by a personal representative of patient)____________________