



Jennifer K. Hargleroad, DDS, MS  
Professional LLC  
Pediatric Dentistry

Dear Parents:

We would like to thank you for bringing your children to our practice. Your child will be a welcome addition to our patient family.

In order to facilitate your medical history information and insurance processing, please bring the following information with you to child's first appointment.

- Name and dosage of any medication currently prescribed
- Name of employer
- Name and address of dental insurance company
- Group and policy number
- Social Security Number and Date of Birth of the policy holder
- Medicaid Card
- CHP Plus Card and Child's Social Security Number

Please complete the enclosed Get-Acquainted Questionnaire and Medical History Form. Ensure that you complete all questions for both forms. We also request that you review the Office Policy and the Privacy Practices forms prior to your child's visit. We will have you sign for these forms electronically at the first appointment.

Our goal is to maintain fees as low as possible. We request payment on the day services are rendered. Dental insurance plan benefits will be applied to this fee during your visit and the balance (if any) can be paid by cash, check or credit card.

We recognize the importance of your personal schedule and will plan your appointment to effectively utilize your time.

Again, we welcome you and your family to our practice and look forward to seeing all of you.

Sincerely,

Jennifer K. Hargleroad, DDS, MS

**PATIENT REGISTRATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Preferred Name: \_\_\_\_\_

**Responsible Party**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_  
Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
E-mail: \_\_\_\_\_

**Patient Information**

Same as above  
Address: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City: \_\_\_\_\_ State / Zip: \_\_\_\_ / \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_  
Sex:  Male  Female  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_  
E-mail: \_\_\_\_\_

Employment Status:  Full Time  Part Time  Retired  
Student Status:  Full Time  Part Time  
Medicaid ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
Insured Soc. Sec/ ID#: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_  
Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other  
Insured Soc. Sec/ ID #: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_  
Address: \_\_\_\_\_ Address: \_\_\_\_\_  
Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_  
Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Who is responsible for making appointments? \_\_\_\_\_

Please provide a friend or relative who can be contacted in case of emergency:

NAME: \_\_\_\_\_ RELATION: \_\_\_\_\_ PHONE: \_\_\_\_\_

Who may we thank for referring you to our office? \_\_\_\_\_

# Medical History

FOR

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your child's mouth, their mouth is a part of their entire body. Health problems that they may have, or medication that they may be taking, could have an important interrelationship with the dentistry they will receive. Thank you for answering the following questions

Primary Care Physician: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Has the patient ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have the patient had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Please list all medications that are currently being taken on an as needed basis: \_\_\_\_\_

Is the patient taking any herbal supplements? If yes, please explain: \_\_\_\_\_

Is the patient on a special diet? \_\_\_\_\_

Does the patient use tobacco? \_\_\_\_\_

Does the patient use controlled substances? \_\_\_\_\_

Are the patients immunization up to date? ..... Y N (?)

If no, please explain: \_\_\_\_\_

Women: Are You

Pregnant / trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other If yes, please explain: \_\_\_\_\_

**Do you have or have you had any of the following?**

|                           |     |                          |     |                              |     |  |     |
|---------------------------|-----|--------------------------|-----|------------------------------|-----|--|-----|
| AIDS/HIV Positive         | Y N | Drug Addiction           | Y N | Hives or Rash                | Y N | Spina Bifida                             | Y N |
| Anaphylaxis               | Y N | Easily Winded            | Y N | Hypoglycemia                 | Y N | Stomach/Intestinal Disease               | Y N |
| Anemia                    | Y N | Emphysema                | Y N | Irregular Heartbeat          | Y N | Stroke                                   | Y N |
| Arthritis/Gout            | Y N | Epilepsy or Seizures     | Y N | Kidney Problems              | Y N | Swelling of Limbs                        | Y N |
| Artificial Heart Valve    | Y N | Excessive Bleeding       | Y N | Leukemia                     | Y N | Thyroid Disease                          | Y N |
| Artificial Joint          | Y N | Excessive Thirst         | Y N | Low Blood Pressure           | Y N | Tonsillitis                              | Y N |
| Asthma                    | Y N | Fainting Spell/Dizziness | Y N | Lung Disease                 | Y N | Tuberculosis                             | Y N |
| Blood Disease             | Y N | Frequent Cough           | Y N | Liver Disease                | Y N | Tumors or Growths                        | Y N |
| Blood Transfusion         | Y N | Frequent Diarrhea        | Y N | Mitral Valve Prolapse        | Y N | Vision problems                          | Y N |
| Breathing Problem         | Y N | Frequent Headache        | Y N | Pain in Jaw Joints           | Y N | Ulcers                                   | Y N |
| Bruise Easily             | Y N | Glaucoma                 | Y N | Parathyroid Disease          | Y N | Venereal Disease                         | Y N |
| Cancer                    | Y N | Hay Fever                | Y N | Psychiatric Care             | Y N | Yellow Jaundice                          | Y N |
| Chemotherapy              | Y N | Heart Attack/Failure     | Y N | Radiation Treatments         | Y N | Autism                                   | Y N |
| Chest Pains               | Y N | Heart Pace Maker         | Y N | Recent Weight Loss           | Y N | Birth Defects or genetic disorders       | Y N |
| Congenital Heart Disorder | Y N | Heart Trouble/Disease    | Y N | Renal Dialysis               | Y N | Developmental Disabilities               | Y N |
| Convulsions               | Y N | Heart Murmur             | Y N | Rheumatic Fever              | Y N | Attention Deficit Disorder/Hyperactivity |     |
| Cold Sores/Fever Blisters | Y N | Hemophilia               | Y N | Rheumatism                   | Y N | Disorder and/or                          |     |
| Cortisone Medicine        | Y N | Hepatitis A              | Y N | Scarlet Fever                | Y N | Obsessive Compulsive Disorder            | Y N |
| Diabetes                  | Y N | Hepatitis B or C         | Y N | Shingles                     | Y N | Cerebral Palsy                           | Y N |
|                           |     | Herpes                   | Y N | Sickle Cell Disease or trait | Y N | Cleft lip or palate                      | Y N |
|                           |     | High Blood Pressure      | Y N | Sinus Trouble                | Y N | Growth Problems                          | Y N |

**DENTAL HISTORY**

Why is the patient seeking dental care? \_\_\_\_\_

Is this the patient's first visit to the dental office? ..... Y      N

    If no, give date of last visit: \_\_\_\_\_

Are you anxious about your child's dental care? ..... Y      N

Has either parent had a lot of tooth decay? ..... Y      N

Has the patient had any of the following dental problems?

    Injuries to the mouth or head? ..... Y      N

    Toothaches? ..... Y      N

    Abscesses (gum boils)? ..... Y      N

Does your child have fluoride in drinking water? ..... Y      N

Does your child use fluoride toothpaste? ..... Y      N

Did the child ever sleep with their bottle or sippy cup? ..... Y      N

At what age was bottle or breast feeding stopped? \_\_\_\_\_

How often are the child's teeth brushed? \_\_\_\_\_

Who brushes the child's teeth? \_\_\_\_\_

Does child floss teeth? \_\_\_\_\_

Does child eat sugar-coated cereal for breakfast? \_\_\_\_\_

Does child eat more than 3 meals and 2 snacks per day? \_\_\_\_\_

Has the patient had orthodontic treatment in the past, ( Y/N) or present, (Y/N)?

If so, who is the provider: \_\_\_\_\_

**DOES THE PATIENT HAVE ANY OF THE FOLLOWING HABITS?****Past****Present**

|  |   |   |   |   |     |
|--|---|---|---|---|-----|
| Tooth grinding.....                                  | Y | N | Y | N | (?) |
| Cheek biting.....                                    | Y | N | Y | N | (?) |
| Tongue thrusting.....                                | Y | N | Y | N | (?) |
| Mouth breathing or snoring while sleeping.....       | Y | N | Y | N | (?) |
| Eating disorder .....                                | Y | N | Y | N | (?) |
| Finger or thumb sucking.....                         | Y | N | Y | N | (?) |
| Gum chewing.....                                     | Y | N | Y | N | (?) |
| Does your child drink soda pop on a daily basis..... | Y | N | Y | N | (?) |
| Does your child drink juice on a daily basis.....    | Y | N | Y | N | (?) |

Other (specify) \_\_\_\_\_

**SOCIAL AND BEHAVIORAL HISTORY**

Do you think the patient will cooperate for dental treatment? ..... Y      N      (?)

Has the patient had a bad or fearful dental or medical experience? ..... Y      N

Is there any additional information we should know?

    If yes, comment \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

**SIGNATURE OF PATIENT, PARENT OR GUARDIAN** \_\_\_\_\_ **DATE** \_\_\_\_\_

## GENERAL OFFICE POLICIES

Because your child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any and/or all necessary treatment is performed by Dr. Jennifer K. Hargleroad. The signature of a parent or guardian affixed below authorized the completion of all agreed upon dental treatment. This consent for treatment shall remain in full force and effective until cancelled by either party. Such cancellation must be in writing and in no way relinquishes responsibility of a current balance. Furthermore, I will be responsible for any bill incurred on this child for dental treatment.

- ❖ For your comfort, one parent, or accompanying adult, is welcome but not required to accompany your child to the operator. However, for the safety and privacy of other patients, **all others**, including children who are not scheduled at this appointment, are asked to remain the reception room. Young children in the reception room will need a supervisory adult.
- ❖ The use of cell phones is prohibited in the operator. The conversations carried on by others present in the clinical area are distracting to children, preventing us from close, careful communication with each young patient.
- ❖ Please make every effort to keep your child's appointment at the time scheduled. Kept appointments help us serve you better. In order to provide the best treatment for your child in a timely way, it is imperative that we provide the proper number of supporting staff and schedule adequate treatment time. A last minute change or failed appointment means the preparation procedures as well as the appointment time are wasted. Currently, we do not charge for broken appointments as many practices do; nor do we want to use that protocol. However, you are missed when an appointment is broken or canceled at the last minute. Please notify us as soon as possible if you cannot keep an appointment so the time may be given to another patient.
- ❖ In order to see our patients in a prompt manner at scheduled appointment times, if you are more than ten minutes late to your child's scheduled appointment time, we will try our best to see your child, but you may be asked to reschedule the appointment.
- ❖ The responsible party for the account is the parent that brings the child in for the dental visit, independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.
- ❖ As a courtesy to you, our office will submit the necessary insurance claims for scheduled appointments. We do ask for the estimated co-payment for procedures at the time of service. Since all insurance companies, plans, and policies differ, we ask that you inform our staff of the benefits surrounding your policy. We will make every effort to base co-payments on this information.

Thank you for your understanding. Your cooperation in these matters helps us to serve your child better.

You will be asked to sign an electronic signature pad at your child's dental appointment to acknowledge reviewing these office policies.

Effective date of notice: June 01, 2005

## **NOTICE OF PRIVACY PRACTICES**

Jennifer K. Hargleroad, DDS, MS

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Fort Collins, CO 80525

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### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

We respect our legal obligation to keep health information that identifies you private. We are obligated by law to give you notice of our privacy practices. This Notice describes how we protect your health information and what rights you have regarding it.

#### **TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

The most common reason why we use or disclose your health information is for treatment, payment or health care operations. Examples of how we use or disclose information for treatment purposes are: setting up an appointment for you; examining your teeth; prescribing medications and faxing them to be filled; referring you to another doctor or clinic for other health care or services; or getting copies of your health information from another professional that you may have seen before us. Examples of how we use or disclose your health information for payment purposes are: asking you about your health or dental care plans, or other sources of payment; preparing and sending bills or claims; and collecting unpaid amounts (either ourselves or through a collection agency or attorney). "Health care operations" mean those administrative and managerial functions that we have to do in order to run our office. Examples of how we use or disclose your health information for health care operations are: financial or billing audits; internal quality assurance; personnel decisions; participation in managed care plans; defense of legal matters; business planning; and outside storage of our records.

We routinely use your health information inside our office for these purposes without any special permission. If we need to disclose your health information outside of our office for these reasons, we usually will not ask you for special written permission.

We will ask for special written permission in the following situations: requested by patient or personal representative to release records to another health care provider .

#### **USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION**

In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us; some may never come up at our office at all. Such uses or disclosures are:

- when a state or federal law mandates that certain health information be reported for a specific purpose;
- for public health purposes, such as contagious disease reporting, investigation or surveillance; and notices to and from the federal Food and Drug Administration regarding drugs or medical devices;
- disclosures to governmental authorities about victims of suspected abuse, neglect or domestic violence;
- uses and disclosures for health oversight activities, such as for the licensing of doctors; for audits by Medicare or Medicaid; or for investigation of possible violations of health care laws;
- disclosures for judicial and administrative proceedings, such as in response to subpoenas or orders of courts or administrative agencies;
- disclosures for law enforcement purposes, such as to provide information about someone who is or is suspected to be a victim of a crime; to provide information about a crime at our office; or to report a crime that happened somewhere else;
- disclosure to a medical examiner to identify a dead person or to determine the cause of death; or to funeral directors to aid in burial; or to organizations that handle organ or tissue donations;
- uses or disclosures for health related research;

- uses and disclosures to prevent a serious threat to health or safety;
- uses or disclosures for specialized government functions, such as for the protection of the president or high ranking government officials; for lawful national intelligence activities; for military purposes; or for the evaluation and health of members of the foreign service;
- disclosures of de-identified information;
- disclosures relating to worker's compensation programs;
- disclosures of a "limited data set" for research, public health, or health care operations;
- incidental disclosures that are an unavoidable by-product of permitted uses or disclosures;
- disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information;

Unless you object, we will also share relevant information about your care with your family or friends who are helping you with your dental care.

## **APPOINTMENT REMINDERS**

We may call or write to remind you of scheduled appointments, or that it is time to make a routine appointment. We may also call or write to notify you of other treatments or services available at our office that might help you. Unless you tell us otherwise, we will mail you an appointment reminder on a post card, and/or leave you a reminder message on your home answering machine or with someone who answers your phone if you are not home.

## **OTHER USES AND DISCLOSURES**

We will not make any other uses or disclosures of your health information unless you sign a written "authorization form." The content of an "authorization form" is determined by federal law. Sometimes, we may initiate the authorization process if the use or disclosure is our idea. Sometimes, you may initiate the process if it's your idea for us to send your information to someone else. Typically, in this situation you will give us a properly completed authorization form, or you can use one of ours.

If we initiate the process and ask you to sign an authorization form, you do not have to sign it. If you do not sign the authorization, we cannot make the use or disclosure. If you do sign one, you may revoke it at any time unless we have already acted in reliance upon it. Revocations must be in writing. Send them to the office contact person named at the beginning of this Notice.

## **YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION**

The law gives you many rights regarding your health information. You can:

- ask us to restrict our uses and disclosures for purposes of treatment (except emergency treatment), payment or health care operations. We do not have to agree to do this, but if we agree, we must honor the restrictions that you want. To ask for a restriction, send a written request to the office contact person at the address, fax or E Mail shown at the beginning of this Notice.
- ask us to communicate with you in a confidential way, such as by phoning you at work rather than at home, by mailing health information to a different address, or by using E mail to your personal E Mail address. We will accommodate these requests if they are reasonable, and if you pay us for any extra cost. If you want to ask for confidential communications, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask to see or to get photocopies of your health information. By law, there are a few limited situations in which we can refuse to permit access or copying. For the most part, however, you will be able to review or have a copy of your health information within 30 days of asking us (or sixty days if the information is stored off-site). You may have to pay for photocopies in advance. If we deny your request, we will send you a written explanation, and instructions about how to get an impartial review of our denial if one is legally available. By law, we can have one 30 day extension of the time for us to give you access or photocopies if we send you a written notice of the extension. If you want to review or get photocopies of your health information, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- ask us to amend your health information if you think that it is incorrect or incomplete. If we agree, we will amend the information within 60 days from when you ask us. We will send the corrected information to persons who we know got the wrong information, and others that you specify. If we do not agree, you can write a statement of your position, and we will include it with your health information along with any rebuttal statement that we may write. Once your statement of position and/or our rebuttal is included in your health information, we will send it

along whenever we make a permitted disclosure of your health information. By law, we can have one 30 day extension of time to consider a request for amendment if we notify you in writing of the extension. If you want to ask us to amend your health information, send a written request, including your reasons for the amendment, to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

- get a list of the disclosures that we have made of your health information within the past six years (or a shorter period if you want). By law, the list will not include: disclosures for purposes of treatment, payment or health care operations; disclosures with your authorization; incidental disclosures; disclosures required by law; and some other limited disclosures. You are entitled to one such list per year without charge. If you want more frequent lists, you will have to pay for them in advance. We will usually respond to your request within 60 days of receiving it, but by law we can have one 30 day extension of time if we notify you of the extension in writing. If you want a list, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.
- get additional paper copies of this Notice of Privacy Practices upon request. It does not matter whether you got one electronically or in paper form already. If you want additional paper copies, send a written request to the office contact person at the address, fax or E mail shown at the beginning of this Notice.

## **OUR NOTICE OF PRIVACY PRACTICES**

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as well as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Web site.

## **COMPLAINTS**

If you think that we have not properly respected the privacy of your health information, you are free to complain to us or the U.S. Department of Health and Human Services, Office for Civil Rights. We will not retaliate against you if you make a complaint. If you want to complain to us, send a written complaint to the office contact person at the address, fax or E mail shown at the beginning of this Notice. If you prefer, you can discuss your complaint in person or by phone.

## **FOR MORE INFORMATION**

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown at the beginning of this Notice.

You will be asked to sign an electronic signature pad at your child's dental appointment to acknowledge reviewing this notice of privacy practices.