Office Use Only **COOP** Poor Fair Good **OHI** Poor Fair Good

PANO____ BWZ ____ PA'S ____ PROPHY ____ FLO ____

ADAVEN CHILDREN'S DENTISTRY Travis Neu, DMD Nina Mirzayan, DDS

Today's Date: _____ Referred by: _____

Patient's Name: _____ _____ Nickname: _____
Last First

Date of Birth: _____ Gender: Male / Female Age: _____ Reason for Visit: _____

Primary Care Doctor: _____ Number: _____

Health History:

1. Is patient being treated by a physician currently? Yes / No If yes, why? _____

2. Has patient been hospitalized in the past? Yes / No If yes, why? _____

3. Has patient received general anesthesia? Yes / No If yes, why? _____

4. Does patient have any allergies? (medicine, food, etc) Yes / No If yes, what? _____

5. Is patient taking any medicine currently? Yes / No If yes, what? _____

6. Has patient ever been diagnosed with any of the following conditions? Yes / No **If yes, please circle below.**

AIDS/HIV	Cerebral Palsy	Excessive Bleeding	Nutrition Problems
Anemia	Chicken Pox	Eye Problems	Pneumonia
Asthma	Cleft lip/palate	Fainting	Rheumatic Fever
Autism	Convulsions/Seizures	Hearing Loss	Scarlet Fever
Bladder	Diabetes	Heart Condition	Scoliosis
Blood disorder	Down Syndrome	Hepatitis	Sickle Cell Anemia
Brain Injury	Emotional Problems	Measles	Spina Bifida
Cancer	Epilepsy	Mumps	Whooping Cough

Other? Explain: _____

Dental History:

1. Has patient been seen by a dentist before today? Yes / No If yes, when and what services were provided?

_____

2. Is patient complaining with any dental problem? Yes / No If yes, explain below.

_____

3. Has patient ever received fluoride in any form? Yes / No If yes, explain below.

What form? _____When? _____

4. Are patient's teeth brushed daily? Yes / No How many times? _____ What toothpaste? _____

5. Does patient have any oral habits? (thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc) Yes / No If yes, explain?

_____

6. Has patient had any unhappy dental experience? Yes / No If yes, explain.

_____

7. At what age did patient stop bottle/breast feeding? _____

Patients Name: _____

Financial Responsibility:

Father/Guardian: _____SS#: _____DOB: _____

Address: _____City: _____State/ZIP: _____

Email: _____Phone #: _____

Does this number receive text messages? Yes / No

Permission to send email and/or text messages? Email: Yes / No Text: Yes / No

Mother/Guardian: _____SS#: _____DOB: _____

Address: _____City: _____State/ZIP: _____

Email: _____Phone #: _____

Does this number receive text messages? Yes / No

Permission to send email and/or text messages? Email: Yes / No Text: Yes / No

Insurance Information:

Patient's Dental Insurance Company: _____

Guarantor: _____Employer: _____

Member ID #: _____ Group #: _____Ins. Phone #: _____

Ins. Address: _____City: _____ State/ZIP: _____

Permission to Accompany in Parent/Guardians absence:

I hereby authorize the following person to act in my behalf to obtain treatment for my child in my absence:

Name: _____ Relationship to Patient: _____

Phone #:_____ Revoke Date:_____

Emergency Contact (other than parents listed above):

Name: _____ Phone #: _____

Relationship to patient: _____

Authorizations:

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my minor/child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child. **I understand and agree that (regardless of my insurance status), that I am ultimately responsible for the balance of my account for any professional services rendered.**

_____

Name of Parent/Guardian

_____ _____

Signature of Parent/Guardian Date

Adaven Children's Dentistry

Travis Neu, DMD and Nina Mirzayan, DDS
2843 St. Rose Pkwy. Ste 100
Henderson, NV 89052

Office Policies and Procedures

Welcome to Adaven Children's Dentistry. Our mission is to provide quality dental treatment in a caring environment for you and your child/children. We hope to promote good, long-term attitudes toward dentistry and oral health. We provide the following information in order to familiarize you with our office policies. All medical information and consent forms must be completed and signed prior to examination. **Please do not make any alterations to this form.**

Only Parents/Legal Guardians Can Give Consent:

Only parents/legal guardians can accompany the patient for dental visits for our office. If you are not the natural parent or legal guardian of the child you are accompanying, please do not sign this form. This form must be read and signed prior to the visit by the natural parent or guardian and brought in with the identification of the parent/guardian. We must have original signatures on all forms including any medical history form, insurance form and consent form. If you are the legal guardian of the child, but not the natural parent, you must provide legal documentation as well as identification at the time of the first visit. If we cannot determine custody or guardianship for the patient, the appointment will be rescheduled until the proper documentation can be provided. If the parent/guardian has granted you permission to bring the child in, we must have the proper authorization on file.

Our Treatment Room Policy:

Parents/Guardians may accompany patient/patients in treatment areas. A complete diagnosis and a standard pediatric set of x-rays will be taken *if the child is cooperative.* The doctor will discuss patient diagnosis and recommend a treatment plan and treatment options. However, it is very important that the patient be allowed to establish a rapport with the doctor and staff during treatment. If the patient becomes uncooperative or combative, you may be asked to step outside the treatment room until the doctor is able to establish control. *We do not allow other children/siblings in the treatment area during procedures.*

Sedation/Nitrous:

The doctor may recommend sedation medication be given prior to treatment as they deem necessary due to fear and/or anxiety of patient. This pre-medication is generally Demerol and Atarax given orally in the office one hour prior to appointment as a sedative and relaxant. In addition, nitrous oxide (laughing gas) is used on most children requiring dental treatment.

Behavior Management Techniques:

In order to provide quality dental work and reduce the risk of injury, it is absolutely necessary that the patient remain still during treatment. Despite our efforts to calm a child with reassurances, explaining the instruments and their noises, at time we encounter difficult management problems. If a patient is uncooperative, it may be necessary to use one of the following behavior management techniques to facilitate treatment.

1. ***Voice Control:*** Instruction is given in a controlled firm tone of voice.
2. ***Physical Restraint (Papoose board):*** This is a padded board with a velcro blanket designed to safely wrap the arms and legs of a child in addition to holding the patient's head in place. The papoose board is also designed to provide motion control so that the patient and our staff are protected during a dental procedure. This is used as a "last resort" in young patients who we, might otherwise, be unable to treat. If the papoose board becomes necessary, you will be informed first. It is most commonly used for emergencies of very young patients and/or to stabilize a patient after treatment has begun and then becomes uncooperative. The doctor reserves the right to make the decision if the papoose board is necessary.
3. ***Out-patient Surgery Center:*** This may be recommended for very young patients, or those with medical problems, which would otherwise prevent them from being treated in the normal office setting, or difficult to manage patients. General anesthesia is administered in this case in an outpatient surgical facility.

Adaven Children's Dentistry

Travis Neu, DMD and Nina Mirzayan, DDS
2843 St. Rose Pkwy. Ste 100
Henderson, NV 89052

Office Policies and Procedures

Silver and White Fillings:

Most insurance companies will only cover the cost of silver fillings on primary (baby) teeth. If you prefer a white filling for your child, or if it is recommended by the doctor, your insurance company may not cover the cost. As the responsible party, you would be required to pay the different in cost between the silver and white filling, with averages about $20-$50 difference per tooth. We will be happy to provide that cost to you ahead of time of treatment.

Silver Diamine Fluoride (SDF)

Silver Diamine Fluoride 38% is a medicament that can be used in dentistry to stop and/or slow the progression of a cavity. SDF does the following:
-Provides immediate relief for sensitive teeth.
-Kills bacteria
-Hardens softened tooth structure making it more acid and abrasion resistant
-Does not stain sound dentin or enamel (healthy teeth)
-Will stain decayed teeth
-Can temporarily stain the cheeks and gums in the area where the SDF is being applied

X-Ray Policy:

It is important for the doctor to have high quality, diagnostic x-rays available at the time of the patient's initial exam. If you can provide us with x-rays from a recent visit (within 6 months) to another dentist, we will be happy to accept those. If we do need to take a set of x-rays, and your insurance company declines payment, the responsible party will be financially responsible for the cost. We do our best to obtain accurate information from your insurance company regarding frequency limits for all exams, x-rays, cleanings, etc, but ultimately it is responsible party's financial responsibility.

Family Appointments:

We try to accommodate same-day sibling appointments and we appreciate the time saving convenience afforded to you by doing this. It does, however, block a major portion of our schedule and therefore, it is pertinent that these appointments be kept as scheduled. Failure to keep a "family" appointment could result in the inability for us to offer these same-day sibling appointments. **We require at least a 24 hour notice to cancel or reschedule all appointments and reserve the right to assess a missed appointment fee if we do not receive that notice.**

Please notify a staff member if you have questions about the above information.

_____
Patients Name

_____ _____
Parent/Guardian Name **Relationship to Patient**

_____ _____
Parent/Guardian Signature **Date**

Adaven Children's Dentistry

Travis Neu, DMD and Nina Mirzayan, DDS
2843 St. Rose Pkwy. Ste 100
Henderson, NV 89052

ASSIGNMENT OF BENEFITS

Patient Name: _____

Policyholder: _____

I hereby instruct and direct my insurance _____

to: Adaven Children's Dentistry, 2843 St. Rose Pwky. Ste 100 Henderson, NV 89052 or if my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows: Adaven Children's Dentistry, 2843 St. Rose Pkwy. Ste 100 Henderson, NV 89052 for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I hereby authorize ADAVEN CHILDREN'S DENTISTRY to deposit any checks received from my Insurance Company for my account when made payable to me.

_____ _____

Signature of Policyholder Date

_____ _____

Signature of Claimant, if not policyholder Signature of Witness

Adaven Children's Dentistry

Travis Neu, DMD and Nina Mirzayan, DDS
2843 St. Rose Pkwy. Ste 100
Henderson, NV 89052

Notice of Privacy Practices Acknowledgement

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

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

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the users 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 organization at anytime at the address above to obtain a current copy of *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 healthcare operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

<u>Office Use Only</u>

I attempted to obtain this patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:
Initials:
Reason:

Adaven Children's Dentistry

Travis Neu, DMD and Nina Mirzayan, DDS
2843 St. Rose Pkwy. Ste 100
Henderson, NV 89052

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT FOR WHOM CONSENT IS BEING GIVING

Name: _____

Section B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of the other important matters about your protected health information. A copy of our Notice accompanies Consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our HIPAA Compliance Officer, Travis Neu.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Consent Person listed about. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue if you revoke this Consent.

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices, I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

_____ _____

Parent/Guardian Signature Date

OR:

REVOCATION OF CONSENT (sign only if revoking consent)

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that the revocation of my consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat me after I have revoked my Consent.

_____ _____

Parent/Guardian Signature Date