

Dr. Michael J. Purcell
1640 Fortino Blvd.
Pueblo, CO 81008
543-7123

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

“YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT”

I, _____, have received a copy of this office’s Notice
of Privacy Practices.

(Child’s Name *Please Print*)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- () Individual refused to sign
- () Communications barriers prohibited obtaining the acknowledgement
- () An emergency situation prevented us from obtaining acknowledgement
- () Other (Please Specify)

RELATIVES/FRIENDS

| | | |
|-------------|---------|--------------|
| GRANDMOTHER | ADDRESS | PHONE NUMBER |
|-------------|---------|--------------|

| | | |
|-------------|---------|--------------|
| GRANDFATHER | ADDRESS | PHONE NUMBER |
|-------------|---------|--------------|

| | | |
|------------|---------|--------------|
| AUNT/UNCLE | ADDRESS | PHONE NUMBER |
|------------|---------|--------------|

| | | |
|--------|--|--|
| FRIEND | | |
|--------|--|--|

RESPONSIBLE PARTY

I understand that I am responsible for all charges that are incurred by me or my family regardless of insurance coverage. (PAYMENT IS DUE AT THE TIME OF SERVICES RENDERED) If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for the collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Michael J. Purcell D.D.S., P.C. on any unpaid bills for services furnished by me or my family. I authorize the release of any dental information necessary to process this claim and all future claims.

Signature

Date

OFFICE POLICY

1. Only ONE parent may accompany child during treatment.
2. Only the child with the appointment may enter the treatment area.
(This may cause distraction)
3. NO Cell Phones permitted beyond office waiting room.
4. If you are 15 minutes late you may be asked to reschedule your appointment.
5. If your child's appointment is not verbally confirmed the day before, we may schedule over the appointment and you may be asked to rescheduled.
6. Payment in full is EXPECTED at the time of service.

PEDIATRIC DENTISTRY INFORMED CONSENT
FOR PATIENT MANAGEMENT TECHNIQUES

Please read this form carefully and ask about anything you do not understand.
We will be pleased to explain.

Our goal is to provide the best possible dental care to each child patient, however, providing high quality of care can sometimes be compromised, made difficult, or even sometimes impossible, due to the lack of cooperation by a child patient. Among the behaviors that can interfere with our professional care being delivered to a child include, but are not limited to: Hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform necessary dental treatment, aggressive or physical resistance to treatment, which may include kicking, screaming and grabbing the dentist and/or his/her agent's hands which may hold sharp dental instruments.

In the event we cannot obtain the cooperation of the child patient, there are several alternatives in behavior management techniques that may be used to gain cooperation of the child patient to eliminate disruptive behavior or prevent a patient from causing injury to him/herself due to uncontrollable movements. The very difficult and uncontrollable patient may be wrapped with a blanket to protect him or her from injuring him/herself.

We do not use drugs or sedative medication on any child patients without separate specific consent.

If you have any questions, please feel free to talk to the Dentist at any time.

I hereby acknowledge that I have read and understand the Pediatric Dentistry Informed Consent for Patient Management Techniques, and that all questions about the behavior management techniques and alternatives have been answered in a satisfactory manner. I further understand that I have a right to be provided with answers to any questions that may arise during the course of my child's treatment.

I further understand that this consent shall remain in effect until terminated by me.

Date: _____

Patient's Name: _____

Signature of Parent or Guardian: _____

Witness: _____ Dentist: _____

PREVENTATIVE DENTAL HISTORY

How often does your child brush?

Is tooth brushing supervised?

By whom?

Is dental floss used?

Does your child receive: Yes No

- *Fluoride:
- *Fluoride tablets/drops:
- *Fluoridated water:
- *Bottled water:
- *Well water:

MICHAEL J. PURCELL, D.D.S., P.C.

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FATHER/MOTHER

Father's Full Name

Address

City State Zip

SS# Birthdate

Home Phone # Business Phone #

Employer Occupation

Mothers Full Name

Address

City State Zip

SS# Birthdate

Home Phone # Business Phone #

Employer Occupation

INSURANCE

Primary Insurance Group #

Policy Holder's Name Membership #

Secondary Insurance Group #

Policy Holder's Name Membership #

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

The permission of parent or guardian is necessary for dental treatment of a minor.

I give the doctors permission to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic reactions to drugs, food, insect bites, anesthetics, pollens, dust, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Signature Relationship to Child Date

Reviewed by: Doctor Date