



- 1220 Oak Park Dr., Fort Collins, CO 80525 ~ Phone (970) 223-8687 ~ Fax (970) 225-1574
 - 383 W. Drake Rd, #103, Fort Collins, CO 80526 ~ Phone (970) 377-2500 ~ Fax (970) 207-1971
 - 1122 9th St., #101, Greeley, CO 80631 ~ Phone (970) 353-5203 ~ Fax (970) 353-9441
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Hi,

I would like to welcome you and your family to your first visit to the ToothZone! To make sure everything goes smoothly on the day of your child's appointment, please review and complete the enclosed forms contained in this folder. A self-addressed, stamped envelope has been included for your convenience in returning the completed paperwork. Please understand that incomplete or missing paperwork impacts our ability to deliver on-time, quality service to you and your child. We pride ourselves on running an on-time practice and we trust you will make every effort to arrive a few minutes early with all paperwork completed on the day of your first visit.

Health History:

It is *extremely* important that we receive the completed health history. The doctors need this information to anticipate situations where they may need to consult your child's physician. In order for our team to properly prepare for your child's first visit, we must receive the health history **prior** to the scheduled appointment.

1. Insurance:

We serve many patients whose dental plans feature various deductibles and coverage. In light of this fact, please note:

- We are **not** a member of any insurance network or plan.
- We **will** assist you in working with your insurance by filing for reimbursement on your behalf, on the date of service. We do this electronically in an effort to save you the time and hassle of filing from home.
- We encourage you to contact your insurance company prior to your first appointment to confirm that your plan allows you to seek out-of-network care.

2. Payment:

Regardless of whether or not you have dental insurance, we do ask for payment in full at the time services are rendered. To assist with this, we have the following methods of payment available to you: cash, check, credit card, *Express Pay*, and payment plans through Dental Fee Plan or Care Credit. Please take a minute to review the enclosed sheet that explains our *Express Pay* program and alternate payment options in greater detail.

As always, we are here to assist you in any way. Please call our office if you have any questions or concerns regarding the enclosed paperwork or details concerning your child's first visit. We look forward to meeting you.

Welcome to ToothZone!

Pam Short
New Patient Coordinator

Your child(ren)'s appointment is: _____
Please mail the forms **NO LATER THAN:** _____ or bring them in with you **completed**.



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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.
 (ToothZone Office: (970) 223-8687(TOTS))

_____ M / F
 Child's Name (Last, First) _____ Child's Nickname _____ Date of Birth _____ Weight _____

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:

- | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>(Y) (N)
 _____ Anemia
 _____ Blood Disease
 _____ Blood Transfusions
 _____ Bruises Easily
 _____ Hemophilia
 _____ Sickle Cell Trait or Disease</p> <p>(Y) (N)
 _____ Asthma
 _____ Respiratory Problems
 Disease/RSV
 _____ Heart Surgery
 _____ Heart Murmur/Defect
 _____ High Blood Pressure
 _____ Rheumatic Fever</p> <p>(Y) (N)
 _____ Arthritis
 _____ Bone/Joint Problem TMJ
 _____ Headaches
 _____ Metabolic Disorder
 _____ Muscle Disorder</p> | <p>(Y) (N)
 _____ Aids/HIV
 _____ Cancer or Malignancy
 _____ Chronic Illness
 _____ Diabetes
 _____ Epilepsy
 _____ Hepatitis/Liver disease
 _____ Kidney Disease
 _____ Transplant _____</p> <p>(Y) (N)
 _____ Birth Defects
 _____ Child Abuse
 _____ Concussion
 _____ Growth Problems
 _____ Premature Birth
 _____ Surgery _____
 _____ Syndrome _____</p> <p>(Y) (N)
 _____ Brain Injury
 _____ Developmental Delays
 _____ Hearing and/or Speech Problems
 _____ Hyperactivity/ADD/ADHD
 _____ Neurological Disorder</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

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? _____



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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 you 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

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.

Also, the undersigned consents to the use of agreed upon x-rays, study models, photographs or any other diagnostic aids used for educational purposes. I fully understand this consent and have no further questions.

Signed: _____ Date: _____



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TELL US ABOUT YOUR CHILD!

It is important to children that they are treated with fairness, respect and trust. Often *talking about their world* outside of the dental office instills those feelings better than any other means. Getting to know your child is also fun for us! In an effort to get to know your child better, please answer the following:

Parent(s): _____

Child's Full Name: _____

Nickname: _____ **School:** _____

Siblings:	Name:	Age:
1.	_____	_____
2.	_____	_____
3.	_____	_____

Hobbies/Activities/Interests:

What is your child's greatest concern in coming to the dentist?

Please circle any of the following words that may describe your child:

Determined	takes risks	good listener	reserved/shy
Self-reliant	fun loving	thoughtful	practical
Competitive	creative	sympathetic	detailed
Leader	optimistic	avoids conflict	orderly

Please list in order from 1-6 (1=lowest, 6=highest), what is most important to you in the dental care of your child:

_____ Addressing and fixing the problem I came for
_____ Overall health of my child
_____ Financial arrangements and cost of care
_____ Teaching my child how to be a good patient
_____ Becoming educated regarding my child's oral health.
_____ Establishing a preventative program of dental care.
_____ Other _____



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FINANCIAL INFORMATION

We find that our clients appreciate knowing in advance what is expected of them financially and what terms and conditions are available. Please read the following information carefully. If you should have any questions, please direct them to one of our Financial Administrators.

As a condition of treatment by this office, all fees are due and payable at the time of service. We gladly accept cash, personal checks, and most major credit cards for payment of your account. For your convenience, we also work with Care Credit and Capitol One. Please ask our financial administrators for information on these outsourced financial plans.

For patients who carry dental insurance, similar terms apply. We request that you pay in full at time of service or pay an estimated portion of your days' service and leave a credit/debit card on file. If you choose to leave a card on file with us, as a courtesy, we will submit your claim for you and once insurance pays, charge your card for any remaining portion. 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. We cannot collect overdue insurance claims or negotiate settlement on disputed claims. 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. We will not resubmit claims until this has been done.

_____ (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 you provide to us. On day 31, if your insurance company has not reimbursed our office, the responsibility reverts to you. Balances not paid within 60 days will be subject to collection. _____ (initial)!

APPOINTMENT COMMITMENT

To best meet the needs of our patients and their families, the ToothZone is an "On Time Dental Practice". When we schedule an appointment for your child, two events occur: 1) we will hold that appointment time for your child in our appointment book and, 2) we trust you will arrive on time for that appointment. If you are late for an appointment, we will do our best to fit you in our schedule. However, it may be necessary for us to reschedule your appointment. Please note that repeated cancellations with less than a 24-hour notice may result in you being charged a \$25 fee. _____ (initial)!

Our office is open Monday through Thursday from 8:00 – 5:00 PM and on Friday from 8:00 until Noon. (Our office is closed from 12:00 – 1:55 PM, Monday through Thursday.) Should you have appointment needs, concerns (or questions regarding your statement, please do not hesitate to call us: 223-8687 (TOTS).

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 grant by permission to 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 of Parent / Guardian)

(Date)



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PATIENT INFORMATION

Date: _____

Patient's Name: _____
Last First Sex: M/F Date of Birth Age Social Security Number

Patient's Name: _____
Last First Sex: M/F Date of Birth Age Social Security Number

Patient's Name: _____
Last First Sex: M/F Date of Birth Age Social Security Number

Address: _____
Street City State Zip

How Long? _____ Previous Address (If less than 3 yrs.) _____

Home Phone: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Marital Status _____
Last First Middle

Relationship to Patient: _____

Residence: _____
Street City State Zip

Email Address: _____ (for appointment reminders only)

Mailing Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ SS #: _____ - _____ - _____ Occupation: _____

Employer: _____ Years Employed: _____

Employer's Address: _____

Name: _____ Marital Status _____
Last First Middle

Relationship to Patient: _____

Residence: _____
Street City State Zip

Email Address: _____ (for appointment reminders only)

Mailing Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ SS #: _____ - _____ - _____ Occupation: _____

Employer: _____ Years Employed: _____

Employer's Address: _____

EMERGENCY INFORMATION

Who should we contact in case of an emergency (other than responsible party): _____

Phone: _____ Relationship to Patient: _____

Complete Address: _____

Name of nearest relative not living with you: _____ Phone: _____



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INSURANCE / CHANGE OF INSURANCE FORM

Today's Date: _____

Subscriber's Name: _____

Subscriber's DOB: _____

Subscriber's SS# or ID: _____

Subscriber's Place of Employment: _____

Date of new insurance or date change became effective: _____

Is this insurance your primary or secondary insurance company? _____

Name of New Insurance: _____

Mailing Address: _____

Group Number: _____

Telephone Number _____

Fax Number: (If Available) _____

With the exception of the FAX Number, the information requested above **is necessary** for us to file your insurance claim. If you are unable to complete the information, we will not be able to file your claim. You will need to pay for your visit today in full, unless you have made prior arrangements with our Financial Administrator. Thank you.



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EXPRESS CHECK-OUT

Making your Dental Experience Faster and Easier!

Toothzone is now offering easy and convenient payment options for you, designed to save you and your children valuable time and the hassle of waiting in line.

Here is how EXPRESS CHECK-OUT works!

At your child's routine cleaning and exam appointments, we will discuss and/or schedule any dental treatment that may need to be done. At that time, you may choose from a variety of payment options, which will be taken care of automatically at these future visits. When your child is finished, you are done and out the door! No more waiting in line.

The Advantages of EXPRESS CHECK-OUT

You will save:

- Valuable time.
- The trouble of writing and mailing checks.
- The hassle of watching for statements and monitoring your balance.
- The inconvenience of coordinating your payments with insurance payments.
- And *older kids* can bring themselves to the dentist!

EXPRESS CHECK-OUT Payment Options

- **Pre-payment** by cash, check, debit or credit card. (No post-dated checks please).
- **Express Pay/Place your debit or credit card on file with us.** Your credit or debit card will be charged for your estimated portion on the day of service, then if any balance remains after your insurance payment is received. We will ask you to update this process upon the expiration date of your credit or debit card.

Our up to the minute technology allows us to efficiently and accurately track your payments, making life much easier and simpler for you and your family. To sign up today, complete the EXPRESS PAY AUTHORIZATION FORM in this packet.

As always, please do not hesitate to call if you have any questions at (970) 223-8687.



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EXPRESS PAY AUTHORIZATION FORM

I hereby authorize *W. Kent Obermann, DDS, MS*, to keep my signature on file and to charge my credit/debit card selected below for the following:

1. All visits from _____ to _____
(Month - Day - Year) (Month - Day - Year)

2. Charges for the following family members: (Include first and last names)

- _____
- _____
- _____
- _____
- _____

Mark One: ___ Visa ___ MasterCard ___ American Express ___ Discover

Cardholder's Name: _____

Circle One: Credit / Debit Card Card Number: _____

Expiration Date: _____

I understand this form is valid unless I cancel this authorization through written or verbal notice to ToothZone.

Cardholder Signature: _____ Date: _____

**WE CANNOT CALL CLIENTS PRIOR TO CHARGING/DEBITING YOUR CARD.
Please call anytime if you have questions.**



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Here at ToothZone we strive to never allow cost or insurance benefits to dictate needed treatment for your child. For our patients with dental insurance, we are pleased to offer you two options.

Option One- Payment at time of service. Of course we love this option!! If you choose to pay for services up front and receive direct reimbursement from your insurance company, we will be happy to submit your insurance claim as a courtesy to you.

Option Two- Payment after insurance benefits. With this option we require an estimated portion of your days' service to be paid at time of service. We further request that a credit/debit card number be kept securely on file. Once we have received payment from your insurance company we charge any remaining balance to your card. This alleviates the need for mailed statements and checks lost in the mail.

Ninety percent of insurance companies pay within 30 days. However, if you have not received your Explanation of Benefits (EOB) within 30 days, please contact your insurance company for payment resolution. You should expect to receive your EOB from your insurance provider 3-5 days before we receive reimbursement in our office. This allows you the opportunity to anticipate when your card will be debited for your portion of the fees due.

If, after 35 days of your visit, we still haven't received payment from your insurance company a statement will be sent to you reflecting the full amount due. If needed, we will resubmit your insurance claim one (1) time for you. We will extend to you an additional 19 days to receive payment from your insurance company before we will charge your card for the full amount due.

Please be aware that **we cannot call clients prior to debiting your card.** However, we do mail you a receipt along with a copy of your ledger reflecting a zero balance.

Here at ToothZone we are aware and sensitive to the issues surrounding identity theft. Our security standards meet and exceed HIPAA requirements and our computer system is equipped with the latest firewall technologies. When processing your credit information, your card number is truncated to only reveal the last 4 digits, in accordance with state law.



RESPONSIBLE PARTY SIGNATURE

DATE



FINANCIAL ADMINISTRATOR

DATE