Jarod Oliver, D.D.S.
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Smiles by GJO
Children's Dentists & Orthodontists

Cele Oliver, D.D.S., D.H.Sc
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PATIENT HISTORY

In order to ensure your/your child's safety, comfort and happiness during dental treatment, we need to obtain information from you. Please carefully and completely answer the questions below. Thanks!

PRINT:

Patient's Name_____Nickname (if any)_____
First Middle Last

Date of Birth_____ Age_____ Sex: M F
Month Day Year

Attends what school? _____Grade_____

Brothers and Sisters:

_____ _____
Name Age Name Age

_____ _____
Name Age Name Age

Pets_____
Kind of Pet and Name

Interests or hobbies_____

PATIENT DENTAL HISTORY

What is your chief concern for this appointment? _____
_____

Is this the patient's first visit to a dentist? Yes No
If not, how long since the last dental visit? _____

Previous dentist:
Name_____
Phone# _____

Approximate date of last dental X-Rays _____

Does the patient currently have any dental problems, or have they ever had any major dental problems in the past? Yes No
If so, please explain_____

Has the patient ever had an unpleasant dental experience? Yes No
If so, please explain_____

FAMILY DENTAL HISTORY

Do any dental problems run in your family? Yes No
If so, please explain _____

Please rank the following family members' decay history:

Mother (past or present cavities):	Many	Average	Few	None
Father (past or present cavities):	Many	Average	Few	None
Siblings (brothers or sisters):	Many	Average	Few	None

CAVITY PREVENTION HISTORY

Does the patient receive fluoride daily?
Yes We have it in our water
Yes Takes a fluoride supplement daily
No We do not have fluoride in our water or give supplements

Does the patient …
Use a toothpaste containing fluoride? Yes No
Use other fluoride products (gels or rinses) Yes No

How often are patient's teeth brushed daily? 1 2 More Less

Who brushes the patient's teeth? Child Parent We Take Turns
Other _____

Is the patient familiar with dental floss? Yes No

GROWTH AND DEVELOPMENT

Does the patient have a bite problem? Yes No
Does the patient have a speech problem? Yes No
Does the patient have any oral habits such as sucking a thumb, finger, pacifier, lip or nail biting, grinding, etc.? Yes No
(*Circle All That Apply*)

PATIENT MEDICAL HISTORY

Primary Care Physician:
Name_____
Address_____
Phone Number_____

Does the patient have regular medical examinations? Yes No
Is the patient currently under a physician's care for any reason? Yes No
Has the patient had any surgery, serious illness, or accident in the past or have any surgery/medical treatment planned? Yes No
If so, please explain_____

Does the patient currently have fever, flu, strep throat, pink eye, fever blisters, ring worm, or hand/foot & mouth? Yes No

Has the patient had any history of:

Heart Trouble or Heart Murmur *(that is currently being monitored by a cardiologist)*	Yes	No
ADHD	Yes	No
Diabetes	Yes	No
Kidney or Liver Disorder	Yes	No
Epilepsy/Seizures	Yes	No
Cerebral Palsy	Yes	No
Seasonal Allergies	Yes	No
Asthma	Yes	No
Anemia	Yes	No
Arthritis	Yes	No
Blood Disorder or Blood Transfusion	Yes	No
AIDS or HIV	Yes	No
Hepatitis	Yes	No
Cancer	Yes	No
Radiation Treatment	Yes	No
Sickle Cell Anemia	Yes	No
Delayed Development	Yes	No
Complication w/ Nitrous Oxide	Yes	No
Complication w/ Local Anesthesia	Yes	No

Does the patient have any mental, emotional, or physical delay or condition? Yes No
If so, please describe_____

Is the patient allergic to any medications, foods, or latex? Yes No
If so, please list_____

Is the patient currently taking any medications? Yes No
If so, please list_____

Please complete the Responsible Party Information: **Date**_____

Responsible Party #1:

Name_____ DOB: _____

Relationship to Patient ☐ Self ☐ Parent ☐ Step-Parent ☐ Grandparent ☐ Other _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partner

Home Address Street_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

Occupation_____ Employer_____

SSN _____ DL State/# _____

Responsible Party #2

Name_____ DOB: _____

Relationship to Patient ☐ Self ☐ Parent ☐ Step-Parent ☐ Grandparent ☐ Other _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Partner

Home Address Street_____

City_____ State_____ Zip_____

Home Phone_____ Work Phone_____

Cell Phone_____ Email_____

Occupation_____ Employer_____

SSN _____ DL State/# _____

Does your child reside with both parents? _____ If not, then who is custodial guardian? _____

Permission is hereby granted to the doctor and staff to perform an initial dental examination and treatment which may include preventive education, x-rays, dental cleaning, fluoride treatment, and orthodontic consultation. *(Note: Some insurance plans may not cover some procedures due to age/frequency limitations. Our office gives you an estimate of charges for treatment appointments; actual charges may differ due to conditions found during treatment. Please remember we accept insurance assignment as a courtesy to you. If your insurance company pays less than the estimated amount or does not pay within 60 days you will be billed for the balance.)* I understand and give consent for treatment.

Signature_____**Date**_____

Who is financially responsible for this account? _____

Is your/your child's dental care covered by a dental insurance program? ☐ Yes ☐ No

If so, please complete the following:

Are you/your child covered by more than one dental program? ☐ Yes ☐ No

If so, please list both below:	First Insurance	Second Insurance
Subscriber (covered employee)		
Employer providing insurance		
Name of insurance carrier (company)		
Insurance ID number		
SSN of Subscriber		
Date of Birth of Subscriber		
Relation to Patient:	☐Parent ☐Step-Parent ☐Other: _____	☐Parent ☐Step-Parent ☐Other: _____

If applicable, please present any legal document that states which insurance is considered Primary.

How did you find out about our office?

☐ Referred by physician or dentist ☐ Referred by friend ☐ Insurance ☐ Another child in the family ☐ Other_____

Whom may we thank for referring you to our office?

Name_____ Address_____

OFFICE POLICIES

Welcome to our practice!

Dr. Cele Oliver, DDS, DHSc and Dr. Jarod C. Oliver, DDS are committed to delivering the best and most comprehensive dental and orthodontic care available. The following information is provided to introduce you to our practice philosophy and policies.

Late or Cancelled Appointments

We kindly ask for two business days' notice for rescheduling appointments. Depending on the appointment type, a $50 fee may be assessed for cancelling without sufficient notice or failing to show. In order to respect the time of other patients, we may find it necessary to reschedule those patients arriving more than 10 minutes late for their appointment. Multiple missed appointments may result in the dismissal from the practice. We appreciate your consideration.

Treatment Plans

If CDO Smiles has recommendations for you/your child, you will receive an itemized list of the recommended treatment. This will also contain an estimate of what the fees will be for the recommended treatment. If you have dental insurance, the treatment plan may include an additional estimate calculating what may be paid by your insurance company toward the fees for your treatment. Treatment plan estimates are not a guarantee of insurance payment and you are ultimately responsible for all fees generated by you/your child's treatment. A deposit may be required to reserve a treatment appointment. Please make arrangements to provide payment prior to the completion of your treatment and/or the day of your appointment. If you choose to discontinue care before treatment is complete, any refund will be determined upon review of your case. Payment plans are subject to approval on a case-by-case basis only.

Payments

Payments for professional services are due at the time services are rendered. This includes any deductible and co-insurance. We accept Cash, Check, Visa, MasterCard, American Express, Discover Card, and Care Credit. Returned check payments are subject to a $40 fee. Unless we approve other arrangements in writing, the balance on your statement is due and is payable when the statement is issued. A late fee of up to 10% may be applied monthly to any past due balance. If your account becomes delinquent, we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all the collection costs that are incurred.

Insurance

You authorize CDO Smiles to release any necessary information requested by your insurance carrier and authorize payment directly to the office for any benefits available under your insurance plan. Insurance is a contract between you and your insurance company. Benefits are not determined by our office, and all deductibles and co-payments will be considered at the time payment is due. We will bill your insurance company as a courtesy to you. Please note that services are not rendered on the assumption that the insurance company will pay us. You are ultimately responsible for payment of all fees generated by your treatment. If your insurance company has not paid your claim within ninety (90) days after the date of service, the full amount is due and payable by you. We will promptly refund to you any insurance payments we receive if you have already paid the balance on your account. It is your responsibility to inform us of any changes in your insurance coverage and to provide multiple insurances if choosing to do so prior to services rendered.

Children and Adolescents

As a board-certified pediatric dentist, Dr. Cele is happy to start seeing children at their first dental visit. Parents are welcome to accompany their children in the operatories. We require that parents remain in the office with children under the age of 18 for the entire appointment. Failure to comply may result in the appointment being rescheduled.

Unaccompanied Minors

When an unaccompanied minor comes for an appointment, the proper consent form(s) must be signed before the appointment and the child must be prepared to pay any payment due. We are also happy to take a credit card from the parent or guardian over the phone prior to the appointment. If another adult brings your child to the office (such as a grandparent or other family member), please provide them with any payment due.

Divorce

In case of a divorce or separation, the parent who authorized treatment prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. CDO may require official copies of the decree for authorization purposes only. The doctors and staff at CDO Smiles are not mediators and will not serve as mediators under any circumstances.

HIPPA and Privacy Practices

Our office is HIPAA compliant and is committed to meeting or exceeding the expectations mandated by HIPAA. You are entitled to receive a copy of our privacy practices, so please let us know whether you would like to receive a printed copy or an electronic copy.

By signing below, I verify that I understand and agree to this policy.

Patient Full Name (printed): _____

Relationship to Patient: _____ Full Name if not patient (printed): _____

Patient or Guardian Signature: _____ Date: _____

14801 San Pedro Ave • San Antonio, TX 78232

Phone 210-495-5437

CDOSmiles.com

NOTICE OF PRIVACY PRACTICES

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.

Smiles By CDO is committed to protecting your privacy, and we have adopted privacy practices to protect the information we gather from you. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. The Notice of Privacy Practices ("Notice") describes the privacy practices of Smiles By CDO and will tell you about the ways in which we may use and disclose medical information about you and how you can get access to this information. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information with respect to your "Protected Health Information" (as defined by the Health Insurance Portability and Accountability Act of 1996 and its regulations, as amended from time to time).

We typically use or share your health information in the following ways:
• Treat you. We can use your health information and share it with other professionals who are treating you. An example of this would be a doctor treating you for an injury asks another doctor about your overall health condition.
• Bill for your services. We can use and share your health information to bill and get payment from health plans or other entities. An example of this would be sending a bill for your visit to your insurance company for payment.
• Run our office. We can use and share your health information to run our practice, improve your care, and contact you when necessary. An example would be an internal quality assessment review.

How else can we use or share your health information. We are allowed or required to share your information in other ways – usually to contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information, see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.
• Help with public health and safety issues. We can share health information for certain situations, such as: preventing disease, reporting suspected abuse, neglect, or domestic violence, preventing/reducing a serious threat to anyone's health or safety.
• Comply with law. We can share information about you if state or federal law requires is, including the Department of Health and Human Services.
• Do Research. We can use and share information for health research.
• Family and Friends: We may disclose your health information to a family member or friend who is involved in your medical care or to someone who helps pay for your care. We may also use or disclose your health information to notify (or assist in notifying) a family member, legally authorized representative or other person responsible for your care of your location, general condition or death. If you are a minor, we may release your health information to your parents or legal guardians when we are permitted or required to do so under federal and applicable state law.
• Organ and tissue donation requests. We can share information about you to organ procurement organizations
• Medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.
• Worker compensation, law enforcement requests, and other governmental requests. We can share health information for worker compensation claims, law enforcement purposes, with health oversight agencies for activities allowed by law, and other specialized government functions (e.g., military and national security)
• Lawsuits and legal actions. We can share health information in response to court or administrative order, or in response to a subpoena.

When it comes to your health information, you have certain rights, we typically use or share your health information in the following ways:
• Get an electronic or paper copy of your medical information. You have the right to inspect and/or obtain a copy of your medical information maintained in a designated record set. If we maintain your medical information electronically, you may obtain an electronic copy of the information or ask us to send it to a person or organization that you identify. To request to inspect and/or obtain a copy of your medical information, you must submit a written request to our Privacy Officer. If you request a copy (paper or electronic) of your medical information, we may charge you a reasonable, cost-based fee.
• Ask us to correct your medical record. You can ask us to correct health information about you that you think is incomplete or incorrect. We may say "no" to your request, but we'll tell you why in writing within 60 days.
• Confidential communications. You can ask us to contact you in a specific way (for instance home or office phone) or to send mail to a different address for items such as appointment reminders. We will say yes to all reasonable requests.
• Limits on what we use and share. You can ask us NOT to share certain health information for treatment, payment, or operations. We are not required to agree to your request, and if it affects your care, we may say no.
• Accounting of disclosures. You can ask for a list (accounting) of the times we have shared your health information for the prior six years. We will include all disclosures, except those about treatment, payment, and operations. We will provide one accounting for free, but may charge a reasonable, cost-based fee if you ask for another within 12 months.

• Privacy Notice. You can ask and receive a paper copy of this notice at any time.
• Complaint. You can file a complaint if you feel we have violated your rights, with the office at the address below, or you with the Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Ave, SW, Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-877-696-6775, or by visiting: www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

In these cases we will never share your information unless given written permission: Marketing purposes, fundraising, and the sale of information.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment, or healthcare operations in the following circumstances:
• If we are required by law to treat you, and we attempt to obtain such consent but are unable to contain such consent; or
• If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you, and we determine that, in our professional judgment, your consent to receive treatment is clearly inferred from the circumstances.

State Law

We will not use or share your information if state law prohibits it. Some states have laws that are stricter than the federal privacy regulations, such as laws protecting HIV/AIDS information or mental health information. If a state law applies to us and is stricter or places limits on the ways we can use or share your health information, we will follow the state law. If you would like to know more about any applicable state laws, please ask our Privacy Officer.

We are required by law to maintain the privacy and security of your protected health information. We will promptly let you know if a breach occurs that may have compromised the privacy and security of your information. This notice is effective as of 2003 and we are required to abide by the terms of the Notice of Privacy Practices. We will not share your information other than described in here unless we receive written authorization. We can change the terms of notice, and any new notices will be available upon request, in our office, and on our website.

If you have any questions or want more information about this notice or how to exercise your health information rights, you may contact our Privacy Officer, Thomas Southam by mail at: 14801 San Pedro Ave or telephone at 210-495-5437. You have the right to exercise any of the actions in the above document, and the Privacy Officer will guide you through the process.

Please mark your selection:

◊ I do NOT authorize any information to be discussed with any family members or friends.
◊ I authorize information about treatment or appointments to be discussed with the following person(s):

_____

_____

I have read and understand the above information.

_____ _____
PATIENT'S First Name Last Name Date of Birth

_____ _____
Patient Signature (or Authorized Representative) Date

For office use only

The following patient/authorized representative _____

◊ Refused to sign the Notice of Privacy Practices because _____

◊ Was unable to sign the Notice of Privacy Practices because _____