We are delighted and honored that you have chosen us to provide your child with the best dental care possible. We love to treat children in our practice!

The first visit to the dentist may be the most important one in your child's life. It's an experience that will help determine and motivate life-long dental health. That's why we go slowly, and take all the time your child needs to feel comfortable. We will do our very best to make your child's dental visit an enjoyable and positive experience. We promise to deliver the highest standard of care, and we welcome all of your questions. Rest assured, most of our team members have children of their own, and we think your children are just as precious as ours.

Whether or not you're allowed to enter the treatment area with your child is a common dental question many parents have -- and there's not always a cut-and-dry answer. The fact is, whether or not a parent or guardian accompanies their child to the dental operatory often depends on the child's individual situation. The American Academy of Pediatric Dentistry recommends that parents of older children remain in the waiting room when children are brought into the dental operatory. Infants and some young children may benefit from having one of their parents in the operatory with them, but it's usually in a child's best interest to be treated without parental interference. Studies have shown that children over the age of 3 often respond better to dental treatment when their parents aren't in sight.

Generally speaking, we invite you to stay with your child during the initial examination. During the initial visit, your toddler might sit on your lap, or next to you, in the dental chair to help put him or her at ease. On subsequent visits, typically most children will be more cooperative when unaccompanied by a parent or guardian. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome any apprehension towards dental treatment.

Of course, we understand that every situation is different. We have advanced training specific to meeting the unique dental needs of children, so you can feel confident that you're leaving your child in excellent hands. By allowing your child to enter the operatory without you, you're placing trust in our office and teaching your child to do the same.

As parents, we are often more apprehensive than our children when it comes to their appointments, so care must be taken not to appear overly concerned. For example, statements such as "Don't worry," or "It won't hurt," can do more harm than good. Children can sense parent's anxiety and discomfort. Using words of encouragement such as "This will be fun," or " It feels good to have healthy teeth," are just a few examples to help them understand that going to the dental office will be a positive experience.

We appreciate you choosing Watertown Dental Care to care for your family. We are passionate about Oral Health and love sharing that passion with all of our patients—young and old—and instilling a lifetime of oral health!

We look forward to meeting you.

Darin Bach, DDS, FAGD, Diplomate, American Board of Dental Sleep Medicine
Hally Bach, DDS
Clayton Conroy, DDS

Watertown Dental Care
600 4th Street NE, Suite 207
Watertown, SD 57201
605.882.0747
www.WatertownDentalCare.com
smile@watertowndentalcare.com

Patient Registration

Patient's Full Name: ____Today's Date: ____________________

Birth Date: ____________ Age: _____ SSN: ____________ Sex: ___ M ___F Full Time Student? ___Yes ___No

Please check one: ___ Single ___ Married ___ Separated ___ Widow Email: ____

Home Address: ______________________________________ City: ______________ State: ______ Zip: ____________

Home Phone: ________________________ Work Phone: ______________________ Cell Phone: _______________________

Emergency Contact: ___________________________________ Relationship: ___________ Phone: ____________________

Medical Contacts: Watertown Dental Care coordinates treatment with your other medical providers when needed to ensure maximum benefit to you. Please list your other medical providers.

Primary Care Physician: _________________________________ Sleep Doctor: ______________________________________

Other Specialist: _____________________________________ Other Specialist: ____________________________________

Person Responsible for Account: ____ SSN: _____________________

Employer: ______________________________________ City: ________________________ State: __________________

Address: ____ Email: ____________________________________

Home Phone: ________________________ Work Phone: ______________________ Cell Phone: _______________________

How Would You Like To Be Contacted About Appointments? ____Telephone ____ Email /Text

May we contact you via home phone and/or cell phone in regard financial questions and information? ______Yes ______No

How Did You Hear About Our Office? ___ Mailed Offer ___ Newspaper ___ Radio ___ Walk-In ___ Website/Social Media

___ Phone Book ___ Billboard Personal Referral (Name: _______________) ___ Special Event (____________________)

Dental Insurance Information (Primary Carrier)

Insured's Name: ______________________________

Relationship to Patient: ________________________

DOB: ________________ SSN: __________________

Insured's Employer: __________________________

Insurance Company: __________________________

Ins. Co. Address: _____________________________

____

Phone #: __________________________________

Group #: __________________________________

ID #: _____________________________________

Secondary Carrier (if applicable)

Insured's Name: _________________________________

Relationship to Patient: _____________________________

DOB: __________________ SSN: ___________________

Insured's Employer: _______________________________

Insurance Company: _______________________________

Ins. Co. Address: _________________________________

____

Phone #: _______________________________________

Group #: _______________________________________

ID #: ____

Patient Registration

Financial Policy

Thank you for choosing Watertown Dental Care as your dental care provider. It is very important to us that we establish the kind of relationship with you that provides the very best of care in the most pleasant environment.

In order to make financial arrangements for your treatment, we offer several flexible options. We accept cash, checks, Visa, MasterCard, Discover, and American Express as well as extended payment plans upon credit approval.

Missed Appointments

Please help us to serve you and all of our patients best by keeping your scheduled appointments. If it is necessary to reschedule an appointment, please give us three business days' notice

Insurance

In most cases, we are happy to accept assignment of insurance benefits from your insurance company. As a courtesy to you we will file your insurance and help you maximize your benefits. We will estimate your insurance coverage and estimate your portion for treatment, which is due on the date of service. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier. <u>It is important to note that the balance on your account is your responsibility regardless of your carrier's coverage. You are responsible for knowing your benefit details.</u>

I hereby authorize my insurance company to assign benefits directly to the office of Drs. Darin and Hally Bach, D.D.S., P.C. I understand that I am responsible for all costs of dental treatment. I authorize Watertown Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the information I have provided on the Patient Registration Forms and Dental and Medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals. I also authorize the use of this signature on all insurance submissions.

Print Name: ____ Signature: ____ Date: _____________

Relationship to Patient: ___ Self ___ Parent/Legal Guardian

Summary of Notice of Privacy Practices

Watertown Dental Care keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect, and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this Notice.

You have a right to a copy of this "Notice" Please check your option below:

____ I am requesting a copy of the Watertown Dental Care "Notice of Privacy Practices"

____ I do not wish to receive a copy of the Watertown Dental Care "Notice of Privacy Practices at this time. I reserve the right to request a copy at a later date.

I have had a full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

You May Refuse to Sign this Acknowledgement

Print Name: ____ Signature: ____ Date: _____________

Patient Registration

Are you covered by Medicare? ☐ *No* ☐ *Yes, Please complete the following:*

PRIVATE CONTRACT WITH PATIENT (OPT-OUT OF MEDICARE)

PARTIES & RECITALS:

A. This is a Private Contract between Dr. Darin Bach, DDS, Dr. Hally Bach, DDS, Dr. Clayton Conroy , DDS (DBA: Watertown Dental Care) and ____ (patient) which allows dentist to provide treatment to patient without being subject to Medicare limits. To do so, the law requires dentist to "opt-out" of Medicare and that no Medicare claim be filed for the treatment of patient by dentist.
B. Drs. Bach, Bach & Dr. Conroy are not excluded from Medicare under Sections 1128, 1156 or 1892 or any other section of the Social Security Act.
C. Drs. Bach, Bach, & Conroy have elected to opt-out of the Medicare program, effective May 26, 2015 and will not be eligible to participate in the program again until May 26, 2017.

AGREEMENTS:

A. Patient or his or her legal representative accepts full responsibility for payment of Drs. Bach, Bach, & Conroy's charge for all services furnished by Drs. Bach, Bach, & Conroy.
B. Patient or his or her legal representative understands that Medicare limits do not apply to what Drs. Bach, Bach, & Conroy may charge for services.
C. Patient or his or her legal representative agrees not to submit a claim to Medicare or to ask Drs. Bach, Bach, & Conroy to submit a claim to Medicare
D. Patient or his or her legal representative understands that Medicare payment will not be made for any items or services furnished by Drs. Bach, Bach, & Conroy that would have otherwise been covered by Medicare, if there was no private contract and a proper Medicare claim had been submitted.
E. Patient or his or her legal representative enters into this contract with the knowledge that he or she has the right to obtain Medicare covered items and services from physicians, dentists, or practitioners who have not opted-out of Medicare, and the patient is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians, dentists or practitioners who have not opted-out. __________**INITIAL HERE**
F. Patient or his or her legal representative understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.
G. Patient or his or her legal representative warrants and represents that Patient does not currently require emergency care services or urgent care services.

EXECUTION AND EFFECTIVE DATE

DENTIST SIGNATURE

PATIENT OR PATIENT'S LEGAL REPRESENTATIVE

RELATIONSHIP TO PATIENT

Original Contract Must Be Retained by Drs. Bach, Bach, & Conroy.
A Copy Will Be Provided to Patient upon request.

Health History

Dental History

Has child complained about dental problems? ☐ YES ☐ NO
Does child brush teeth twice daily? ☐ YES ☐ NO
Does child use floss daily? ☐ YES ☐ NO
Does child drink fluoridated water? ☐ YES ☐ NO
Has child ever received orthodontic treatment? ☐ YES ☐ NO
Has child ever had any mouth, tooth, or head injuries? ☐ YES ☐ NO
Has child ever had any unhappy dental experiences? ☐ YES ☐ NO

Does child have any mouth habits—thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc…? ☐ YES ☐ NO

Previous Dentist:______________________________City:______________________State:__________
Date of last dental visit:__________________________For what service?:______________________________

Medical History

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

Is child under a physician's care now? ☐ YES ☐ NO______________________________________
Has child ever had surgery or been hospitalized? ☐ YES ☐ NO______________________________________
Physician's name and address:____
Is child taking any medications, pills, drugs, herbal supplements, etc...? (If yes, please list all below.) ☐ YES ☐ NO
____
____

ALLERGIES (please circle): Aspirin Penicillin Codeine Acrylic Latex Metal Food Local Anesthetics Other:____________

Does your child have, or has he/she ever had, any of the following?

☐ AIDS/HIV positive	☐ Breathing problems	☐ Drug addiction	☐ Heart trouble/disease	☐ Liver Disease
☐ Anemia	☐ Cancer	☐ Epilepsy or Seizures	☐ Hemophilia	☐ Psychiatric care
☐ Artificial heart valve	☐ Cerebral Palsy	☐ Fainting spells/Dizziness	☐ Hepatitis	☐ Rheumatic Fever
☐ Asthma	☐ Cold sores/Fever blisters	☐ Frequent cough	☐ Herpes	☐ Stomach/Intestinal Disease
☐ Bladder problems	☐ Convulsions	☐ Hearing problems	☐ Kidney problems	☐ Thyroid disease
☐ Blood Disease	☐ Diabetes	☐ Heart murmur	☐ Leukemia	☐ Tuberculosis

Have you ever had any serious illness not listed above? ☐ YES ☐ NO (If yes, please explain:______________________________)

Additional 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 (or Parent/Guardian) Print name Date

______________________________ ____________________
Signature of Doctor Date

Health History Update

PATIENT'S NAME:____

Date:______________________________
Health Changes:______________________________

Current Medications:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Patient's Signature (Parent/Guardian):______________________________Staff Initials:________

Date:______________________________
Health Changes:______________________________

Current Medications:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Patient's Signature (Parent/Guardian):______________________________Staff Initials:________

Date:______________________________
Health Changes:______________________________

Current Medications:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Patient's Signature (Parent/Guardian):______________________________Staff Initials:________

Date:______________________________
Health Changes:______________________________

Current Medications:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Patient's Signature (Parent/Guardian):______________________________Staff Initials:________

Date:______________________________
Health Changes:______________________________

Current Medications:

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Patient's Signature (Parent/Guardian):______________________________Staff Initials:________