



Office of Nicholas A. White, DMD

Welcome to Our Practice! Office Policies

We appreciate you allowing us to provide dental care for your child. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these clarifications of our office policies.

Parent Information

Parents of patients are welcomed to accompany their child during their visit to our office. However, we do recommend after age three, parents allow their children to experience the office without parental support. This allows the child to establish an uninterrupted relationship with the doctor and dental assistant that enables them to gain confidence during dental treatment. Our dental assistants are especially experienced and trained in early childhood behavior and will make a great effort to ensure that your child feels comfortable in these new surroundings. Since this first visit will establish their initial attitudes towards dentistry, it is very important to make this appointment a positive encounter.

Appointment Policy

If your child is under the age of 6 we encourage you to schedule a morning appointment. Your scheduled appointment time has been **reserved** specifically for your child. We require and appreciate **24 hours** notice if you need to cancel a scheduled appointment. If you do miss an appointment without notifying us 24 hours in advance (**no-show**) or you cancel **same day** as appointment, you may be charged a **\$50.00 fee per patient**.

Infection Control

We utilize the most effective infection control measures and fully comply with the new OSHA standards for sterilization. We maximize our use of disposable materials and autoclave all of our hand instruments.

Any questions you have are welcomed!!

I have read and understand the Office Policies and agree to abide by its contents:

PARENT/GUARDIAN _____

DATE: _____

Welcome



Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First Mi

Nickname _____ Male Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

Child's Home # (_____) _____

SS# _____

Child's Home Address: _____

City State Zip

2. Who may we thank for referring you to our office?

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

6. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

City State Zip

Home # (_____) _____

Work # (_____) _____

Cellular # (_____) _____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

Why did you bring the child to the dentist today? _____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding Y N Handicaps/Disabilities

Y N Allergies to any Drugs Y N Hearing Impairment

Y N Any Hospital Stays Y N Heart Disease/Murmur

Y N Any Operations Y N Hemophilia/Blood Disorders

Y N Asthma Y N Hepatitis

Y N Cancer Y N HIV + / AIDS

Y N Congenital Birth Defects Y N Kidney/Liver Conditions

Y N Convulsions/Epilepsy Y N Rheumatic/Scarlet Fever

Y N Pregnancy Y N Allergies to Latex Product

Y N Tuberculosis Y N Diabetes

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all drugs the child is allergic to _____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good Fair Poor

11. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date

Relationship to Patient

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. White and his staff to examine, clean and (after signed treatment plan and consultation) provide my child with comprehensive dental treatment including fillings, crowns, extractions and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. White to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. White will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____

Date: _____

FINANCIAL POLICY

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. If you have been referred by a general dentist, we ask that you pay the cost of the initial examination and any necessary dental x-rays on the day of that appointment. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following outlines our financial policies:

- 1. Payment is Due In Full For Each Appointment As Services Are Rendered:** At our office location we accept cash, Mastercard, Visa, American Express and Discover. We also accept Care Credit. If checks are mailed in for payment, a charge of \$50.00 will be assessed on checks returned for any reason. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.
- 2. Dental Insurance:** The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have **NO** say in the selection of your insurance company, we have **NO** control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits.
- 3. Pre-treatment Authorization:** Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.
- 4. Fillings:** Our dental material of choice is a white (**composite resin**) filling. Please be aware that your insurance company may not pay for a resin filling at the *same* level as a silver (amalgam filling). The co-payment is your responsibility. In some cases, the dentist may recommend placing a silver crown instead of a resin filling.
- 5. Nitrous Oxide:** Nitrous oxide is not usually covered by dental insurance. We thank you for your payment the date of service.
- 6. Ortho-Appliances:** The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when appliances are ordered, not when they are completed.
- 7. Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered.
- 8. Fluoride:** The American Dental Association recommends fluoride treatment 2 x's per year, **HOWEVER**, your Insurance company may cover 1 x per year. Please reference your selected plans guidelines.

Please remember, even if you have insurance coverage, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping us keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping keep your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency. You agree to pay any and all attorney fees associated with the collection of monies due. I have read and understand my obligation.

Signature: _____ Date: _____

*I authorize my insurance to pay directly to my dentist. Our office is an in network provider for Delta Premier and Delta Dental PPO; but our office will try to assist you with filing to most major **PPO** insurance companies. It is at Lake Mary Pediatric Dentistry's discretion as to which policies we will file for. I authorize my insurance company to pay directly to my dentist as an assignment of benefit for treatment rendered. If I am covered by any other plan, I will pay in full when services are rendered. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand I will be responsible for all co-payment, deductible, and rejected charges.*

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES - HIPPA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails or letters).

Patients Rights

Access: You have the right to look at or get copies of your health information. If you request copies we will charge you for each page for staff time to locate and copy the information, and postage if you want the copies mailed.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.

Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means

Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. White.

Signature: _____ Date: _____