



*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 under age three are welcomed to accompany their child. After age three, it is office policy to not allow parent to accompany child; however you are welcomed take a sneak peak after child has settled in. 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. This allows the child to establish an uninterrupted relationship with the doctor and dental assistant that enables them to gain confidence during dental treatment.

### **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: \_\_\_\_\_