We're in the business of making smiles!

OFFICE POLICIES

Welcome to our Practice!

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 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 strongly encourage you to schedule a morning appointment. Your scheduled appointment time has been reserved specifically for your child. We require and appreciate **2 business days notice** if you need to cancel a scheduled appointment. If you do miss an appointment without notifying us **2 business days** in advance (no–show) or you cancel same day as appointment, you may be charged a $100.00 fee per patient _____**(Initial)**. Repeated broken appointments and short term cancellations will be subject to dismissal from the practice. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. **Late arrivals will be re-appointed to another day.**

Video and Camera Policy

In order to protect patient privacy, no videos or pictures are permitted. Please no cell phone use in our treatment areas.

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.

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

Parent/Guardian _____

Date _____

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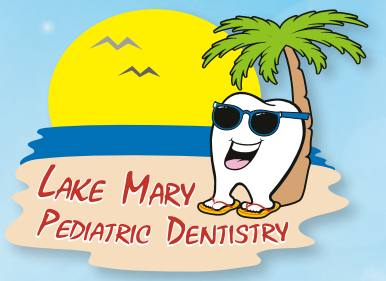

PATIENT INFORMATION

Patient Information

Name _____

Date of Birth _____ / _____ / _____

Age _____ ❑ Male ❑ Female

Child's Address _____

City _____ State _____ Zip _____

Phone (_____) _____

Sibling's Names and Ages _____

_____

What school does your child attend _____

Parent 1 Information

Name _____

Date of Birth _____ / _____ / _____

Employer _____

Cell Phone (_____) _____

Work Phone (_____) _____

Email Address _____

Social Security# _____

❑ Married ❑ Divorced ❑ Separated

May we contact you via Text and/or Email? Y ❑ / N ❑

Parent 2 Information

Name _____

Date of Birth _____ / _____ / _____

Employer _____

Cell Phone (_____) _____

Work Phone (_____) _____

Email Address _____

Social Security# _____

❑ Married ❑ Divorced ❑ Separated

May we contact you via Text and/or Email? Y ❑ / N ❑

Referral

How did you hear about us? _____

Who is accompanying the Child today?

Name _____

Relationship _____

Who has legal placement of the child? _____

Do you have legal custody of this child? ❑ Yes ❑ No

Is the legal guardians billing address the same as the patient? ❑ Yes ❑ No

If not, please provide _____

_____

Primary Dental Insurance

Primary Policy Holder Name _____

Date of Birth _____ / _____ / _____

Social Security# _____

Insurance Co. Name _____

Insurance Co. Address _____

City _____ State _____ Zip _____

Insurance Co. Phone Number (_____) _____

Subscriber ID# _____ Group# _____

Pharmacy Information

Pharmacy Name _____

Pharmacy Location _____

Pharmacy Email Address _____

Pharmacy Phone Number (_____) _____

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Lake Mary Pediatric Dentistry

Winter Park Pediatric Dentistry

HEALTH HISTORY

Child's Name _____

Child's Physician _____

Phone (_____) _____

Date of last physical exam _____ / _____ / _____

Is your child in good health? _____

Has your child had any operations? _____

Are your child's immunizations up to date? _____

Is your child currently taking any medications? _____

Is your child allergic to anything? _____

Please indicate if your child has ever been diagnosed, treated, or is currently being treated for any of the following:

- Y ❑ / N ❑ Abnormal Bleeding
- Y ❑ / N ❑ AIDS/HIV
- Y ❑ / N ❑ Allergies to Latex Products
- Y ❑ / N ❑ Allergies to Medications
- Y ❑ / N ❑ Anemia
- Y ❑ / N ❑ Any Hospital Stays
- Y ❑ / N ❑ Asthma
- Y ❑ / N ❑ Blood Disorder/Transfusion
- Y ❑ / N ❑ Cancer/Tumors
- Y ❑ / N ❑ Celiac Disease
- Y ❑ / N ❑ Cerebral Palsy
- Y ❑ / N ❑ Congenital Birth Defects
- Y ❑ / N ❑ Convulsions
- Y ❑ / N ❑ Diabetes
- Y ❑ / N ❑ Epilepsy/Seizures
- Y ❑ / N ❑ Handicaps/Disabilities
- Y ❑ / N ❑ Hearing/Speech Problems
- Y ❑ / N ❑ Heart Condition/Murmur
- Y ❑ / N ❑ Hepatitis
- Y ❑ / N ❑ Kidney/Liver Conditions
- Y ❑ / N ❑ Pregnancy
- Y ❑ / N ❑ Tuberculosis
- Y ❑ / N ❑ Sensory Disorders

Behavior/Learning

- Y ❑ / N ❑ ADHD
- Y ❑ / N ❑ Anxiousness/Nervousness
- Y ❑ / N ❑ Autism/Aspergers
- Y ❑ / N ❑ Behavior Issues
- Y ❑ / N ❑ Emotional Disability
- Y ❑ / N ❑ Learning Disability
- Y ❑ / N ❑ Psychiatric Disorder
- Y ❑ / N ❑ Social Delays

Please elaborate on any items circled above _____

_____

Was your child breast/bottle fed? At what age was it stopped? _____

Dental History

Has your child ever been to the dentist? ____ If so, whom? _____

Date of their last dental visit _____ / _____ / _____

Has your child ever had dental x-rays? _____

Date of their last x-rays _____ / _____ / _____

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

_____

Do you think your child will react well to dental treatment? If not, please explain. _____

Has your child ever sucked a pacifier, finger or thumb? _____

At what age was the habit stopped? _____

Does your child brush his/her own teeth? How often? _____

_____

Does your child use dental floss? _____

Does your child have juice/milk/soda/snacks between meals? _____

Is your child's water fluoridated? _____

Is your child taking fluoride supplements? _____

Has your child ever had any pain/noise associated with his/her jaw? _____

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.

Parent/Guardian Signature _____

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 _____

_____

_____

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. **Insurance Changes:** We file dental insurance claims as a courtesy, However, it is your responsibility to inform our office of any changes to your dental insurance 2 business days prior to any scheduled appointments.
4. **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.
5. **Fillings:** Our dental material of choice is a White and associates **(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.
6. **Nitrous Oxide:** Nitrous oxide is not usually covered by dental insurance. We thank you for your payment the date of service.
7. **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.
8. **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered.
9. **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.
10. **Divorce Decrees:** This office is not a party to your divorce decree. The responsibility for minors rests with the accompanying adult. All payments are due before treatment is rendered and must be arranged ahead of time for the parties that will not be attending appointment.

Signature _____

Date _____

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PERMISSION CONSENT

Date: _____

Permission Consent

I _____ give my permission for the following person(s) to accompany my child to his/her dental visits. All person(s) listed below must be 18 years of age or older. I understand that I am responsible for payment at the time of services and should someone accompany my child other than myself, arrangements for payment must be made before that scheduled appointment time. I understand that all treatment plans must still be **signed by a legal guardian** before services will be rendered without exception. **(This does not expire until we receive written notification to cancel or amend consent.)**

Name	Relationship to Child

Child's Name: _____

Child's DOB: _____

Parents Signature: _____

Date: _____

Parent Phone # _____

Lake Mary Pediatric Dentistry
Winter Park Pediatric Dentistry
P: (407) 942-0225
F: (407) 930-4647
Email: teeth32746@aol.com

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CONSENT FOR TREATMENT

Consent for Dental Treatment

I request and authorize Dr. White and associates 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 and associates 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 and associates 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 _____

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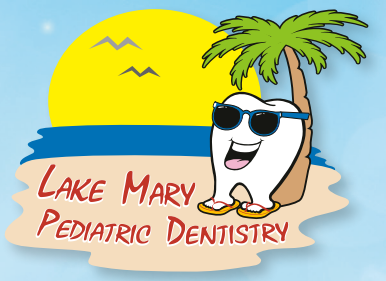

AUTHORIZATION TO DISCLOSE

Authorization to Disclose Protected Health Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information

Name of Patient or Individual: Last _____ First _____ Middle _____

Other Name(s) Used _____

Date of Birth _____ Email Address _____

Address _____ City _____ State _____ ZIP _____

Phone _____ Alt. Phone _____

I AUTHORIZE LAKE MARY & WINTER PARK PEDIATRIC DENTISTRY TO BE ABLE TO DISCLOSE MY PROTECTED HEALTH INFORMATION:

Person/Relationship to patient _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Email Address _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Can we disclose your protected health information to your spouse, adult, child(ren), sibling, or other (examples: Physician, Attorney, Life Insurance Company, Employer, Ex-spouse, non-custodial parent, or other entity?) If yes, please write their name, contact information and relationship to you.

Person/Organization Name _____ Relationship to Patient _____

Address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Email Address _____

REASON FOR DISCLOSURE:

- ☐ **Treatment/Continuing Dental**
- ☐ **Personal Use**
- ☐ **Billing or Claims**
- ☐ **Insurance**
- ☐ **Legal Purposes**
- ☐ **Disability Determination**
- ☐ **School**
- ☐ **Employment**
- ☐ **Other:** _____

WHAT INFORMATION CAN BE DISCLOSED?

Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of these items. If all health information is to be released, then check only the first box.

- ☐ All Health information
- ☐ History/Physical Exam
- ☐ Past/Present Medications
- ☐ Lab Results
- ☐ Physician's Orders
- ☐ Patient Allergies
- ☐ Operative Reports
- ☐ Consultation Reports
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Diagnostic Test Reports
- ☐ Pathology Reports
- ☐ Billing Information
- ☐ Payment Information
- ☐ Radiology Reports
- ☐ Imaging Films
- ☐ Other

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AUTHORIZATION TO DISCLOSE

(continued from previous page)

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)

_____ Genetic Information (including Genetic Test Results

_____ Drug, Alcohol, or Substance Abuse Records (excluding Part 2)

_____ HIV/AIDS Test Results/Treatment

Your initial at this location serves as specific consent to disclose the above described protested information. You acknowledge that this information, once disclosed, may lose its protected status and be subject to redisclosure.

RIGHT TO RECEIVE COPY: The individual and /or the individual's legally authorized representative has a right to receive a copy of this authorization.

EFFECTIVE TIME PERIOD: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; or the specific date (optional): **Month** _____ **Day** _____ **Year** _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "Who can receive and use the health information". I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected. If I revoke this Authorization, I must send a written request to: **Lake Mary Pediatric Dentistry, 974 International Pkwy., Lake Mary, FL. 32746 ATTN: Privacy Officer**.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE:_____ DATE: _____
Signature of Minor Individual

SIGNATURE:_____ DATE: _____
Signature of Parent or Legal Guardian

Delivery Method: _____Mail _____ Email _____ Pick up date: _____

Rejection of Encryption of Email or Electronic Media:

_____ Unencrypted electronic media requested _____ Unencrypted email requested

If electronic delivery of records is requested, either by electronic media or email, delivery shall be made by secure encrypted method. If you chose to decline secure delivery, your election to receive the records through an unencrypted method serves as acknowledgement of the risks associated and waiver and release of Lake Mary & Winter Park Pediatric Dentistry, its parent and subsidiary companies, affiliated entities, directors, officers, employees, and agents ("Released parties") against any and all claims, now or in the future, relating to the unsecure delivery of your health record information

Charges: In accordance with HIPAA, Lake Mary & Winter Park Pediatric Dentistry may charge a reasonable cost-based fee to provide a copy of records requested by you which may include labor for copying the records (but not search and retrieval), supplies for copying on paper or electronic media, postage, and preparation of a summary. If you have agreed to the summary in lieu of the actual record; and in the alternative, if an electronic record was requested and is available, a flat fee of $1.00 per page. If the records request was made by someone other than the patient or patient's representative, fees as specified by the state in which the records are located shall apply. If applicable.

Informed of charge for copies (Please initial) _____

INSURANCE POLICY

Insurance Policy
(PLEASE READ)

Our Practice is not a contracted in network provider for any dental insurance plans. We do accept most major insurance plans with your out of network benefits. Please remember, if you have insurance, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured patient, your employer (human resources), and your selected insurance company. Understanding and cooperation with this matter is greatly appreciated. Past due accounts are subject to a monthly service charge and could be turned over for collections 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 company to pay directly my dentist. Our office will try to assist you with filing to most major PPO insurance companies. it is at Our Practice's discretion as to which policies we will file. I authorize my insurance company to pay directly to my dentist as 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-payments, deductibles, and rejected charges.

Signature _____ Date _____

If you prefer to pay up front for services rendered and submit to your own insurance company for reimbursement, please initial_____