

# 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.

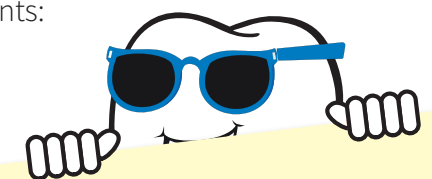
#### Infection Control

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

### Parent 2 Information

Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Employer \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Work Phone (\_\_\_\_\_) \_\_\_\_\_

Email Address \_\_\_\_\_

Social Security# \_\_\_\_\_

☐ Married ☐ Divorced ☐ Separated

### 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# \_\_\_\_\_

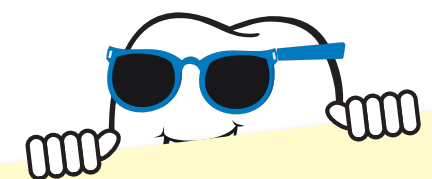
### Pharmacy Information

Pharmacy Name \_\_\_\_\_

Pharmacy Location \_\_\_\_\_

Pharmacy Email Address \_\_\_\_\_

Pharmacy Phone Number (\_\_\_\_\_) \_\_\_\_\_



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## 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:

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

### Behavior/Learning

- |  |   |
|--|---|
| <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> ADHD                    | <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> Emotional Disability |
| <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> Anxiousness/Nervousness | <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> Learning Disability  |
| <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> Autism/Aspergers        | <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> Psychiatric Disorder |
| <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> Behavior Issues         | <input type="checkbox"/> / <input type="checkbox"/> / <input type="checkbox"/> 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 \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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## FINANCIAL POLICY

### 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 (**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.

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 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. 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 \_\_\_\_\_





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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

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Child's Name: \_\_\_\_\_

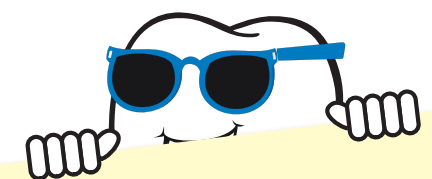
Child's DOB: \_\_\_\_\_

Parents Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Phone # \_\_\_\_\_

Lake Mary 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 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 \_\_\_\_\_



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## HIPAA PRIVACY NOTICE

# NOTICE OF PRIVACY PRACTICES - HIPAA

### 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).

### Patient's 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 our office.

Signature \_\_\_\_\_

Date \_\_\_\_\_

