Lakeview Kids' Dentistry

Patient's Name________________________________ Birth date____________ Gender________
Estimated weight/height__________________School_______________________Grade_____________
Favorite/common snack foods____
Child's hobbies/sports____
Referred by Whom ______________________________

Medical History

Physician________________________ Phone number_________________

Yes No
( ) ( ) Is patient in good health?
( ) ( ) Is patient under a physician's care? For What? ___________________________
( ) ( ) Does patient have any history of major illness? What and When ______________
____
( ) ( ) Has patient ever been hospitalized? For what? ___________________________
( ) ( ) Is patient taking any medications/drugs presently? What? ________________
____
( ) ( ) Does patient have any allergies or drug sensitivities? List:___________________
____
( ) ( ) Have tonsils and/or adenoids been removed? What age? ___________________

Does patient have tendency to colds( ), sore throat( ), ear infections( ), sinus congestion( ), breathing problems( )?

Check any of the following conditions for which the patient has been treated:

( ) AIDS
( ) Arthritis
( ) Asthma
( ) Blood Problems
( ) Bone Disorders
( ) Cerebral Palsy
( ) Diabetes
( ) Epilepsy/Seizures
( ) Emotional Problems
( ) Endocrine Problems
( ) Fainting/Dizziness
( ) Heart Trouble
( ) Hepatitis
( ) HIV Positive
( ) Liver/Kidney Disease
( ) Nutritional Problems
( ) Prolonged bleeding
( ) Rheumatic Fever
( ) Speech, Hearing Problems
( ) Tonsillitis
( ) Tuberculosis

Any other significant medical, psychological, or disability problems, please describe? _______
____

Dental History

Yes No
( ) ( ) Has there been any injuries to the face, mouth or teeth? ____________________________
( ) ( ) Has patient ever sucked thumb or fingers? Until what age? _________________________
( ) ( ) Does the patient have any speech problems? ____________________________________
( ) ( ) Is patient a mouth breather? While awake?_____________ While asleep? ______________
( ) ( ) Does patient have noticeable problems in chewing or swallowing?_____________________
( ) ( ) Does patient see the dentist regularly? Date last seen? ___________________________
( ) ( ) Has any previous dental treatment been attempted/completed? What?_________________
____
( ) ( ) Are supplemental fluorides used? If yes, what?(rinse, gel) __________________________
( ) ( ) Were there any problems with previous dental treatment? If yes, what were they?
____

Is your child up to date on immunizations against childhood diseases? __YES / NO_______

Family General Dentist________________________ Previous Dentist ________________________
How often are the teeth brushed? ________________ Flossed? _______________ By Whom?______
If there are any special concerns please state: ____
____

Parent/Guardian Signature ___________________________ Date ____________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES - FOR YOUR CHILD

Lakeview Kids' Dentistry

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my healthcare provider's *Notice of Privacy Practices* (NOPP) containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices,* importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

WE USE E-MAIL IN OUR OFFICE

We use e-mail to send your and your child's protected health care information to: 1) you 2) others; if you request 3) providers and 4) insurance companies. By providing our office with your e-mail address, you are accepting the risk associated with unsecure e-mail correspondence. If you do not want our office to communicate via un-encrypted e-mail, please mark this box:

☐ DO NOT E-MAIL

Child Name: ___________________________________ Date:______________________

Your Signature: ______________________________________

Your Name and Relationship to Child: ____

Additional Disclosure Authority:

(People to whom we may discuss/release healthcare information: cousins, nannies, orther persons)

Name(s) Relationship(s)

____

____

For Office Use Only: We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason: ___The patient refused to sign __Communication barriers ___Emergency situation___ Other

Lakeview Kids' Dentistry

Financial Policy and Agreement

Outstanding Patient Service is Our Goal

The goal of Lakeview Kids' Dentistry is to make sure that you receive the highest quality dental care and service. One step in achieving this goal is to make certain that our financial policies are clear and that all your questions regarding our financial policies are answered satisfactorily.

Insurance

If you have insurance, we will make a good faith estimate of your benefits and defer billing you for that amount for up to 30 days. We will complete and file the appropriate claim forms on your behalf with your insurance company. We will also track your claim and make sure that it is paid in a timely manner. If your insurer denies coverage, or if we otherwise do not receive full estimated payment within 30 days from filing your claim (the insurance companies must pay claims within 30 days of submission) the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or employer and your insurer. Although we will make every effort to help you obtain your benefits, we cannot force your insurer to pay. Sometimes, in the event your insurance company fails to pay within 30 days, resubmission to insurance may necessitate an additional $20 charge.

Your Payment is Due at the Time of Treatment

Fees for treatment are due at the time of treatment after deduction of your good faith estimate of insurance benefits. We do not offer payment plans.

Payment Options

Cash, Check, Visa, Discover and MasterCard.

Parent/Guardian Responsibility

I acknowledge my responsibility for payment of the services received from Lakeview Kids' Dentistry. I will be the primary parent/guardian responsible for the patient account regardless of other financial arrangements. I understand my responsibility is not modified by whether any third party (insurance) pays for all, part or none of the charges. I understand that this account becomes delinquent if not paid within 30 days after billing. Generally we do not send statements because you're balance should be zero after any insurance payments. If your balance is not zero after 30 days, a statement billing fee of $20 will be charged monthly until the balance is zero. Accounts that are delinquent for multiple months will be forwarded to a collection agency.

I also acknowledge that Lakeview Kids' Dentistry requires 24 hour notice to reschedule or cancel any appointments. If I fail to give the proper notice, I may be required to pay a $50 "broken appointment" fee for each child appointed. I also acknowledge that after hours urgent care dental visits will include a $150 "after hours" fee.

Assignment and Release

I authorize payment to be made directly to Dr. Stuehling and Lakeview Kids' Dentistry by my insurance company and I accept financial responsibility for all services not covered by my insurance and I authorize release of any medical care information requested by my insurance carrier.

Patient Name: ____

Parent/Guardian Signature: ______________________________________

Date: __________________

Lakeview Kids' Dentistry

INFORMED CONSENT FOR PEDIATRIC DENTISTRY

It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered to your child.

Please read this form carefully and ask about anything you do not understand. We will be pleased to answer your questions.

EXAM

Every child is a unique individual thus not every child will require the same treatment to obtain a comprehensive oral examination. Based upon your child's age, teeth present, and tooth position, Dr. Stuehling will determine if radiographs (x-rays) are necessary. In general, the examination appointment also includes cleaning of the teeth and application of topical fluoride. If you have any questions or concerns about our examination procedure, please inform a member of our team.

TREATMENT

If your child should need any dental treatment after the dental examination has been completed, Dr. Stuehling will review the planned treatment with you. Please read the following information regarding dental treatment at our office.

- It is our policy that all treatment options are explained to the parent(s), including treatment alternatives, advantages, and disadvantages of each. Although good results are expected, it is not possible to guarantee success due to the possibility of complications.
- Risks that are occasionally associated with dental treatment procedures include: numbness, swelling, bleeding, soreness, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infection. On rare occasions complications may arise that require hospitalization.
- I agree to remain within the dental office facility where my child is being treated, unless I've made alternate arrangements in advance with the Lakeview Kids' Dentistry team.

I have been advised of the benefits, risks, and possible side effects of proposed treatment, and possible consequences of not receiving the treatment. Treatment alternatives, including no treatment, have been presented to me and all of my questions regarding my child's care have been answered satisfactorily. With my signature I authorize Lakeview Kids' Dentistry to perform a dental exam upon my child and I acknowledge that I have reviewed the possible risks and complication associated with dental treatment.

Patient Name: ____________________________________

Parent/Guardian Signature: __________________________ Date: ___________