CHILDREN'S DENTAL CARE & ORTHODONTICS

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Dear Parent,

When your child visits Children's Dental Care, you can expect the very best quality care for your child. As pediatric dental professionals, our mission is to provide quality comprehensive dental care that leads to an enjoyable experience for your child. Our office and staff are particularly trained and prepared to alleviate your child's fear, apprehension, and anxiety of the dental visit. The comprehensive services we provide include everything from prevention (cleanings, fluoride treatments, sealants, and mouth guards) to treatment (fixing cavities either in the office or under general anesthesia and intermediate and full braces). Advances in dental technology in recent years have improved the dental experience for children with better dental restorative materials and pain free ways of providing care. Composite (white fillings), air-abrasion, and The Wand® are three examples of these technologies utilized at Children's Dental Care. The following, outlines the treatment, techniques and charges we institute for routine care.

1. We provide an exam, cleaning, and fluoride treatment **every six months**.
   Some insurance companies limit their coverage for fluoride treatments to once a year. We follow the American Academy of Pediatric Dentistry's recommendation, which states, "Provide topical fluoride every six months." Fluoride is given every six months unless you consult with our office **prior** to the treatment.

2. Decay detecting x-rays (bitewings) are taken **once a year** or on an as needed basis.

3. We are firm believers in sealant application to prevent decay in the grooves of teeth. Sealants are a protective plastic covering that is placed on the chewing service of the tooth, with about 90% reduction of decay in these grooves. We will guarantee sealants for up to three years of initial placement date to those patients who do not miss their six-month check-up and are current patients to our office. Insurance companies may limit coverage for sealants. If you have questions regarding sealant coverage please check with your insurance company.

4. **We are a mercury free office. This means we do not place silver fillings we only place composite (white) fillings in our patient's teeth. A comparison of traditional amalgams with composites reveals the following advantages of the new materials. Composites (1) are esthetically pleasing; (2) they do not contain mercury; (3) they actually adhere to the tooth surface; (4) They require less removal of sound tooth structure; and (5) are less irritating for the tooth nerves. Your insurance company may only cover up to 50% of these fillings to be placed. Please be advised that any balance remaining after insurance and or estimated patient portion has been paid is the responsible parties' responsibility. We will send in a pre-determination of dental benefits upon request for these services as a courtesy to you.**

5. NO shot, NO pain! Most procedures performed with our Biolase Laser DO NOT require anesthetic injections, which reduces patient fear and anxiety and creates a gentler and more relaxing atmosphere. However, discomfort is based on individual sensitivity to pain, as well as other factors, so not all patients can be treated without anesthetic and therefore will require a local anesthetic in order to provide a comfortable experience.

6. In situations where it is necessary to numb a tooth, The Wand® provides a more comfortable alternative to the traditional syringe "the shot". The Wand® is a computerized injection system that dispenses local anesthetic around the tooth in a relatively pain-free fashion. Thus, the tooth will be numb, but not the tongue and the entire side of the face.

7. Our financial policies are between the patient's responsible party and our office, not the insurance company. We will attempt to aid you in collecting any covered benefits **due the day the treatment is rendered**. Any remaining balance is the responsible parties' responsibility.

We at Children's Dental Care, hope this information will be helpful and that you will have a pleasant experience with our office.

Sincerely,

The Doctors and Staff at Children's Dental Care

PATIENT INFORMATION

Patient's Name: _____
Last First Middle (Full)
__Male__ Female Nickname: _____ Birth Date: _____

DENTAL HISTORY

Reason for Dental Visit: _____
1st visit (New Patient): _____ New to the Area: _____ Changed Dentists: _____
Has your child ever had trouble, problems, or anxiety with previous dental care? _____yes _____no
If yes, please explain: _____
Date of Last Dental Visit: _____ Date of Last X-Rays: _____ Date of Last Fluoride: _____
Frequency of Dental Cleanings: _____ x a year.
How often are your child's teeth brushed? _____ Flossed? _____ By whom? _____
What age did your child stop nursing? _____Taking a bottle? _____
Does your child take vitamins or fluoride supplements? ____ yes ____ no
Do you have fluoride in your water? ____yes ____ no

PLEASE CHECK ANY OF THE FOLLOWING IF THE PATIENT CURRENTLY HAS OR HAS HAD IN THE PAST

__ injuries to face, mouth or teeth
__ gums bleed when brushed
__ clenching or grinding
__ tongue thrusting
__ thumb, finger, lip sucking
__ nail biting
__ mouth breathing
__ pacifier **for how long*_____
__ sensitivity to hot or cold
__ frequent cold sores, blisters, etc.
__ tubes in ears
__ tonsils/adenoids removed
__ speech problems __ speech therapy
__ swellings or lumps in mouth
__ play sports
__ wear a mouth-guard

Other: _____

HEALTH HISTORY

Child's Physician: _____ City: _____ Date of Last Exam: _____
Any current medications? _____
Any adverse reactions to medications? _____
Has child been hospitalized for any reason? __ yes __ no
**If yes, please explain*: _____
Does your child have any physical disabilities? __ yes __no
**If yes, please explain*: _____
Does your child have any hearing, vision, or learning problems? __yes __no

ALLERGIES

__Penicillin
__Augmentin
__Codeine
__Latex
__Food
__Other: _____
__Amoxicillin
__Erythromycin
__Aspirin
__Metal
__Dye
__Zithromax
__Sulfa
__Iodine
__Acrylic
__Pollen/Dust

PLEASE CHECK ANY OF THE FOLLOWING IF THE PATIENT CURRENTLY HAS OR HAS HAD IN THE PAST

__Cerebral Palsy
__Arthritis
__Leukemia
__Bruises Easily
__Tuberculosis
__Fainting Spells
__Emotional Concerns
__High Blood Pressure
__Thyroid Disease
__Rheumatic Fever
__Auto Immune Disease
__Radiation Treatments
__Cystic Fibrosis
__Fetal Alcohol Syndrome
__Heart Murmur **NEEDS** antibiotic

__Frequent Headaches
__AIDS/HIV Positive
__Sickle Cell/Disease
__Asthma
__Sinus Problems
__Tourette's syndrome
__ADD/ADHD
__Pacemaker
__Stomach Problems
__Liver Disease/Jaundice
__Cancer/Tumor
__Herpes
__Cleft lip or Palate
__Chemical Dependency
__Heart Murmur **NO NEED** for antibiotic

__Lung Disease
__Anemia
__Excessive Bleeding
__Breathing Problems
__Epilepsy/Seizures
__Celiac disease
__Pregnancy
__Diabetes
__Hepatitis A-B-C
__Kidney Problems
__Chemotherapy
__Autism
__Mononucleosis
__Down Syndrome
__Other: _____

CONSENT

I have answered and reviewed the information on the questionnaire and is accurate to the best of my knowledge. I understand that this information will be used by Children's Dental Care doctors and staff to help determine appropriate and healthful dental treatment. This treatment also includes local anesthetic as needed and the use of nitrous oxide per my request. If there are any changes in my child's medical status, I will inform Children's' Dental Care. Since at each visit a treatment plan will be presented and the work to be done is explained to me before treatment is begun, I give Children's Dental Care my consent to perform any needed dental treatment. I authorize my insurance company to pay to Children's Dental Care all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Children's Dental Care to release all information necessary to secure the payment of benefits.

I understand that I am fully financially responsible for ALL charges whether covered or not covered or denied by my insurance company.

Signature: _____ Date: _____

(**PAYMENT** is due **IN FULL** at the time of treatment unless prior arrangements have been made.)

REFERRAL INFORMATION

Whom may we thank for referring you to our practice?

__ Doctor Referral (Name): _____
__ Current Patient (Name): _____
__ Insurance Company
__ Location
__ Internet Search
__ School/Daycare Presentation
__ Other: _____

PARENT INFORMATION

Parent's Name: _____ Birth Date: _____ Marital Status: _ Married _ Single
Last First SS# (*required**): _____

Phone (Home): _____ (Work): _____ (Cell): _____ Text acceptance? _ Yes _ No

Address: _____
Street Apt.#

_____
City State Zip Code

Parent's Name: _____ Birth Date: _____ Marital Status: _ Married _ Single
Last First SS# (*required**): _____

Phone (Home): _____ (Work): _____ (Cell): _____Text acceptance? _ Yes _ No

Address: _____
Street Apt. #

_____
City State Zip Code

Primary E-Mail Address (Used for Future Confirmations): _____

Emergency Contact: _____
Name Phone Relationship to the Patient(s)

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE POLICY HOLDER INFORMATION

Name: _____
Last First Middle Initial
Birth Date: _____ ID #: _____ SS #: _____ Group #: _____

Employer Name: _____

Insurance Plan Name and Address: _____

_____

Relationship to the Patient(s): _____

SECONDARY DENTAL INSURANCE POLICY HOLDER INFORMATION

Name: _____
Last First Middle Initial
Birth Date: _____ ID #: _____ SS #: _____ Group #: _____

Employer Name: _____

Insurance Plan Name and Address: _____

_____

Relationship to Patient(s): _____

ALWAYS BRING INSURANCE CARD OR A COPY WITH YOU FOR US TO SCAN

FINANCIAL POLICY

Welcome to our practice! We are pleased you have selected our office for your children's dental care. We are committed to providing you with the best possible care while trying to control our fees and your costs. We need your assistance and understanding with our payment guidelines.

Payment options if you have no insurance:

1. You may choose to pay by cash, check, or credit card on the day that treatment is rendered.
2. If two appointments are needed, you may choose to pay 50% at the first appointment, and the balance at the second appointment. To get the 5% discount you will need to pay for services done that day in full.
3. We also offer special financing through CareCredit.

Payment options if you have insurance:

1. Pre-treatment estimates are sent as a courtesy to you. You may pay your deductible and your portion due at time of treatment by cash, check, or credit card.
2. On extensive treatment (extractions, crowns, or a lot of fillings) requiring two appointments. You may pay 50% at the first appointment and the balance at the second appointment.
3. We also offer CareCredit Card as an option for payment.

PLEASE READ CHANGES

Contracted Insurance: If we are contracted with your insurance company, we must follow our contract with them and their requirements. It is the insurance company that makes the final determination of your eligibility. You agree to pay any portion left after insurance pays. You may request a pre-determination for any treatment that is done.

Non-Contracted Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what the insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by insurance. You may request a pre-determination for any treatment that is done.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. It will show the previous balance and any new charges to the account.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due by the end of the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred (currently **30%** of the unpaid balance)

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation any future treatment or charges for a child will remain the same parent who was the responsible party before the divorce. If the divorce decree requires the other parent to pay all or part of the treatment costs, **it is the authorizing parent's responsibility to collect from the other parent.**

Missed Appointment Fee: A patient who does not show up or cancels with less than 24-hour notice, a $50.00 fee will be charged. This fee must be paid before a new appointment is scheduled. Patients with 3 missed appointments will be asked to transfer their records to another dentist. The 1st missed appointment fee is typically waived.

Returned Checks: There is a $35.00 fee for any checks returned by the bank.

Late Arrivals: Patients/parents are asked to arrive at their appointments before their scheduled appointment time. A grace period of 10 minutes will be permitted for unforeseen delays a parent/guardian may encounter while traveling to the office for the patient's scheduled appointment. If a patient arrives more than 10 minutes late to their appointment, the parent/guardian will be given the option of either being seen that day if the schedule permits, or reschedule the appointment for a later date.

RESPONSIBLE PARTY

Person that signs forms and brings in the child/children for their dental needs

Patient Name(s): _____

Parent/Guardian Name: _____ Relationship to the Patient(s): _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Co-Signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until cancelled in writing. When written cancellation is received, it becomes effective with any subsequent charges.
Effective Date: Once you have signed this agreement, you agree to all terms and conditions contained herein and the agreement will be in full force and effect.

Signature: _____ Date: _____
(Responsible party)

Co-Signature: _____ Date: _____
(Other than responsible party)

Adult (18 years): _____ Date: _____

Adult /Parent-Signature: _____ Date: _____
(If the parent continues to be responsible for adult child 18+ years)

CHILDREN'S DENTAL CARE
CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

SECTION A: GIVING CONSENT

Patient's Name(s): _____

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies the consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice, at any time by contacting:

Contact : Lacey

Telephone: 952-997-7100 Fax: 952-997-2017

Address: 17677 Cedar Avenue, Lakeville, MN 55044

Right to Revoke: You will have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before you received your revocation, and that we may decline to treat your child or continue treating your child if you revoke this consent.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT UPON REQUEST

REVOCATION OF CONSENT

I revoke my consent for you to use and disclosure of my child's protected health information for treatment, payment activities, and health care operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written notice of revocation. I also understand that you may decline to treat or to continue to treat my child after I revoked my consent.

Signature: _____ Date: _____

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Consent to Communicate

This form allows you to name a person (such as a family member or a friend) to attend the patient(s) appointments and communicate with Children's Dental Care on your behalf.

Patient Name(s): _____

_____

Person Authorized: _____ Relationship to the Patient(s): _____

Person Authorized: _____ Relationship to the Patient(s): _____

Person Authorized: _____ Relationship to the Patient(s): _____

Person Authorized: _____ Relationship to the Patient(s): _____

This authorization is valid until revoked.

Signature of Parent/Legal Guardian: _____ Date: _____

Print Name: _____

Relationship to the Patient: _____

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