Lakewood Pediatric Dentistry, PLLC

Jan Carlson, DDS
133 E. Fairmount Ave. Suite 1, Lakewood, NY 14750
(716)-763-0130

Today's Date: ____ / ____ / ____

Child's First Name: _____ Middle Initial: ____ Last: _____ Preferred Name: _____

☐Male ☐Female Age: _____ Date of Birth: ____ / ____ / ____ School: _____

Address: _____ City: _____ State: _____ Zip: _____ Home Phone: _____

Do we see any of this child's siblings (if yes, please list): _____

Please list any favorite interests such as favorite toys, activities, or pets that might help us get to know your child and to make your child feel more comfortable: _____

Please list all persons that you authorize to bring your child to his/her dental appointments: _____

Head Of Household / Person Responsible For Account

Name: _____ Relation to patient: _____

Date of Birth: ___/__/____ Social Security #: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Work Phone: _____ Cell Phone: _____

Email: (used for appointment information): _____

Mother's Information: (☐Guardian ☐Stepmother ☐Foster)

☐Single ☐Married ☐Other

Name: _____ DOB: ___/____/____

Phone: _____ Cell: _____

Address _____

City: _____ State: _____ Zip: _____

SS#: _____

Father's Information: (☐Guardian ☐Stepfather ☐Foster)

☐Single ☐Married ☐Other

Name: _____ DOB: ____/____/____

Phone: _____ Cell: _____

Address _____

City: _____ State: _____ Zip: _____

SS# _____

Insurance Information

Primary Insurance:

Insured's Name: _____

Date of Birth: ____ / ____ / ____

Relationship to patient: _____

Social Security #: _____

Employer: _____

Work Phone #: _____

Dental Insurance Company: _____

Phone #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID #: _____

Group #: _____

Secondary Insurance:

Insured's Name: _____

Date of Birth: ____ / ____ / ____

Relationship to patient: _____

Social Security #: _____

Employer: _____

Work Phone #: _____

Dental Insurance Company: _____

Phone #: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

ID #: _____

Group #: _____

How did you hear about our office? _____

Patient Health History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body.
Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Is your child under a physician's care now (excluding regular check-ups)?	Yes	No	If yes
Has your child ever been hospitalized or had a major operation?	Yes	No	If yes
Has your child had to take any type of antibiotic prior to dental procedures in the past?	Yes	No	If yes
Is your child taking any medications, pills, or drugs?	Yes	No	If yes
Is your child allergic to any medicines or foods?	Yes	No	If yes
Is your child on a special diet?	Yes	No	If yes

Does your child have any of the following conditions? Mark all that apply.

ADHD/ADD	Yes	No	Down Syndrome	Yes	No	Hemophilia or Bleeding Disorder	Yes	No	Muscular Dystrophy	Yes	No
Allergy	Yes	No	Eating Disorders	Yes	No	High or Low Blood Pressure	Yes	No	Neural Tube Defects	Yes	No
Anemia	Yes	No	Ectodermal Dysplasia	Yes	No	HIV or AIDS	Yes	No	Osteogenesis Imperfecta	Yes	No
Arthritis/Bone Disorder	Yes	No	Emotional Disturbance	Yes	No	Immune Disorders	Yes	No	Rheumatic Fever	Yes	No
Asthma	Yes	No	Epilepsy or Convulsions	Yes	No	Infective Endocarditis	Yes	No	Sleep Apnea	Yes	No
Autism	Yes	No	G-Tube	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Bone Marrow Transplant	Yes	No	GERD	Yes	No	Liver Problems/Hepatitis	Yes	No	Thyroid or Endocrine Disorder	Yes	No
Cancer/Radiation/Chemo	Yes	No	Hearing or Vision Loss	Yes	No	Lupus	Yes	No	Tuberculosis or Mononucleosis	Yes	No
Cerebral Palsy	Yes	No	Heart Disease	Yes	No	Mental Disability	Yes	No	Wheel Chair Bound	Yes	No
Chronic Sinusitis	Yes	No	Heart Murmur	Yes	No	Mitochondrial Disorders	Yes	No	Other	Yes	No
Diabetes	Yes	No	Hydrocephalus	Yes	No						

Have you ever had any serious illness not listed above? Yes No If yes

Physician Information

Pharmacy Information

Previous Dental History

Name of previous dentist:

Month/Year last visit:

Date of last bitewing x-ray:

Reason for leaving:

How often does your child visit the dentsit?

My child's attitude toward dentistry is:

Favorable	Yes	No
Unfavorable	Yes	No
Apprehensive	Yes	No

What is the purpose of your chlid's dental visit today?

Routine Care	Yes	No
Mouth or Tooth Pain	Yes	No
Trauma To Teeth / Gums	Yes	No

Comments:

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Jan Carlson and any members of her team to perform the necessary dental services my child may need.

Signature of Patient, Parent or Guardian:

X Date:_____

Lakewood Pediatric Dentistry, PLLC
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(716) 763-0130

Consent Form

I hereby authorize, for the patient named below, examination and treatment by members of the team of Lakewood Pediatric Dentistry, PLLC and any assistants or designees deemed necessary by Dr. Jan Carlson. I am aware that the practice of dentistry and surgery is not an exact science and I acknowledge that no guarantees have been made to me in regards to the result of treatments or examinations in this office.

PHOTOGRAPHS

I authorize the taking of a digital photograph of my child for his/her dental file.

ASSIGNMENT OF BENEFITS AND GUARANTEE OF PAYMENT

I hereby authorize payment of third-party benefits, otherwise payable to me, directly to Lakewood Pediatric Dentistry, PLLC not to exceed the doctor's regular charges. I understand that I am financially responsible to the practice and/or doctor for the below named patient, and I agree to pay Lakewood Pediatric Dentistry, PLLC all amounts incurred by the named patient not covered by a third party payer, due by me at the time of service.

NO SUGAR BUG CLUB CONSENT

I authorize my child's name to be posted in the office and/or on the office website if they become a member of the No Sugar Bug Club, which will allow them to participate in the prize drawing for their outstanding oral hygiene habits.

COMMUNICATION CONSENT

I understand that Lakewood Pediatric Dentistry, PLLC uses phone calls, text messages, and e-mails as a form of communication regarding appointments. I understand that I can opt out of text message and e-mail communication if I choose, and I will make the staff aware of the request.

Patient Name	Patient's Date of Birth
Parent or Guardian Name	Relationship to Patient
Parent or Guardian Signature	Today's Date

INTERPRETER CONSENT

I, _____, read the above statement to _____, and he/she understands and approves consent as stated above.

Interpreter's Signature	Responsible Party Signature	Today's Date

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

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Parent Guidelines

Dear Parents,

You may choose whether or not you accompany your child to the exam chair. Although we sense that some children do better without parents present, we are open to having you with your child. If you choose to be present, please follow the guidelines to improve the chance of a positive experience:

1. **Allow us to prepare your child.** We will use ***'Tell-Show-Do'*** to explain each step of the procedure.

TELL your child about the procedure
SHOW them what we will do
DO what we have explained

2. **Please be supportive of our practice's terminology.** We are selective in our use of words. Our team members try to avoid words that may frighten your child. Please be supportive by NOT USING negative words. Our intention is not to "fool" your child, but rather it is to create an experience that is positive.

Instead Of	***Please Use***
Needle or Shot	Sleepy Juice
Drill	Whistle
Pull or Yank Tooth	Wiggle a tooth out
Decay, Cavity	Sugar Bug
Drill on Tooth	Wash a Tooth
Examination	Count the Teeth
Tooth Cleaning	Tickle the Teeth
Explorer	Tooth Counter
Rubber Dam	Raincoat

3. **Please be a silent observer.** We ask that you sit quietly so we can maintain communication with your child. Children will normally listen to their parents instead of us and may not hear our guidance.

4. **Both the parent and/or team member have the ability to stop treatment.** If at anytime during the course of treatment either party feels that it may be unsafe to continue, for any reason, treatment may be stopped. "Acting out" is normal, but unacceptable during exams and/or treatment.

These are very important ways that you can actively help in the success of your child's visit. We are confident that these guidelines will help us together make your child's dental visit a positive experience.

I have read and fully understand the parent guidelines for Lakewood Pediatric Dentistry , PLLC.
I have been given an opportunity to ask any and all questions and concerns.

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Office Policies

Late Policy

- We have reserved a specific time to spend with your child. It is important to be on time for your visit so we can provide the best dental care possible to your child during the appointment. **If you arrive to our office more than 10 minutes after your scheduled appointment time, you may be asked to reschedule that appointment (this may also require re-scheduling any siblings' appointments also scheduled).**

Failure to Show and Cancellation Policy

- If *any* family member fails to show for a scheduled appointment or cancels without proper 24-hour notice, that family will be sent a warning letter. If *any* family member fails to show for another scheduled appointment or cancels without proper notice, **that family will be charged** $25.00 **missed appointment fee *per child*.** If *any* family member fails to show for another appointment or cancels without proper notice, **ALL family members will become inactive and must seek treatment elsewhere.**

New Patient Appointment Policy

- We will call to confirm new patient appointments a few days before the appointment. Verbal confirmation is required at least 24-hours in advance. **Please keep us up-to-date on phone number changes.** If we do not receive this confirmation, the appointment will be cancelled and he or she will NOT be able to reschedule. If a new patient fails to show for the new patient appointment, he or she **will NOT be able to reschedule.**
- **All new patient paperwork MUST be completed prior to the new patient appointment.** If you are unable to fill out the paper work online via our website, you *must* arrive to your appointment 20 minutes early to complete the paperwork. If the new patient paperwork is not completed prior to the appointment and you do not show up to the appointment 20 minutes early to fill out the necessary paperwork, you will be asked to reschedule that appointment.

Financial Policy

Our Office Policy requires payment in full at the time of service for charges not covered by insurance.

If you have a dental insurance plan and have chosen us as provider for your child's care, it is your responsibility to:

- Find out if we are a **participating provider** for your specific insurance plan.
- Provide us with the information relative to your claim, including but not limited to: insurance card, subscriber ID number and group number, name of the insurance company, subscriber's date of birth, address, employer, and Social Security number. **This information is requested on the Patient Information form**, which we ask you to complete prior to your initial visit.
- Pay for services not covered by your insurance carrier **at the time of service**.

- To assist you with your payment, our office accepts cash, check, Visa, MasterCard, Discover and CareCredit®. This is a convenient, low minimum, no interest monthly payment plan designed to pay for healthcare services not covered by insurance. Visit www.carecredit.com or call 1(800)365-8295 for more information.
- Personal checks are accepted with proper identification (driver's license or photo ID). **A $30.00 overdraft fee** will be charged to your account for each insufficient check.
- If you cannot provide proof of insurance, you will be expected to **PAY IN FULL** at the time of service.
- If your account becomes 90 days past due, your account may be handed over to our collection agency. **You will be responsible for all cost of the collection process, as well as your portion of the dental services.**

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been given the opportunity to read, and receive upon request, a copy of Lakewood Pediatric Dentistry, PLLC's Notice of Privacy Practices.

Patient Name	Patient's Date of Birth
Parent or Guardian Name	Relationship to Patient
Parent or Guardian Signature	Today's Date

You may refuse to sign this acknowledgment.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of Lakewood Pediatric Dentistry, PLLC's Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify): _____

_____

Team Member Signature: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 1st, 2016 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSURE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, generic information, alcohol and/or substance abuse records, and mental health records may be entitles to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information for a specialist providing treatment to you.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, and insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We my disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury, or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation: We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, electronic, mail, or letters).

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has review the research proposal and established protocols to ensure the privacy of your information.

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Judicial and Administrative Proceedings: If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Coroners, Medical Examiners, and Funeral Directors: We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. Me may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising: We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

OTHER USES AND DISCLOSRUES OF PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale for PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

YOUR HEALTH INFORMATION RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting: With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction: You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit or use, disclosure or both, and (3) to whom you want the limits to apply. **We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment** or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested, we may contact you using the information we have.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach: You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice: You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Website or by electronic mail (email).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our office is designed as an open door environment. It is your responsibility to request your child's treatment and/or financial arrangements be discussed in a private area.

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