Welcome

Health History Form   Dr. Lisa LaPresti   Today's Date: ______________

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ______________________________________
Last First MI

Goes by: ______________________ ☐ Male ☐ Female

Siblings that we treat ______________________________

Child's Birthdate _____/_____/_____ Child's Age __________

School___________________________Grade__________

Child's Home # (__________)__________________________

SS#____

Child's Home Address:_______________________________

____
City State Zip

Email Address:_______________________________________

2. Who may we thank for referring you to our office?

____

3. Mother's Information

Name ____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer ______________________________________

Work # (_________)__________________ Ext. __________

Home # (_________)_____________________________

Cellular Phone # (_________)_________________________

SS # ____________________ DL# __________________

4. Father's Information

Name ____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer ______________________________________

Work # (_________)__________________ Ext. __________

Home # (_________)_____________________________

Cellular Phone # (_________)_________________________

SS # ____________________ DL# __________________

5. Who is Accompanying the Child Today?

Name ____

Relationship____

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

6. Person Responsible for Account

Name____

Relationship____

Billing Address ______________________________________

____
City State Zip

Home # (___________)_______________________________

Work # (___________)_______________________________

Cellular # (___________)_____________________________

E-mail ____

7. Primary Dental Insurance

Insurance Co. Name ________________________________

Insurance Co. Address ______________________________

____

Insurance Co. Phone # (___________)___________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name _______________________________

Relationship to Patient______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ___________________________________

Policy Owner's Employer ____________________________

8. Secondary Dental Insurance

Insurance Co. Name ________________________________

Insurance Co. Address ______________________________

____

Insurance Co. Phone # (___________)___________________

Group # (Plan, Local, or Policy #) ____________________

Policy Owner's Name _______________________________

Relationship to Patient______________________________

Policy Owner's Birthdate ______/ ______/ ______

Social Security # ___________________________________

Policy Owner's Employer ____________________________

9. Dental History

Is this your child's first visit to the dentist? ________________

If not, how long since the last visit to the dentist? ____________

Previous Dentist's Name_______________________________

Were any x-rays taken at previous dental visits? ____________

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain________________________________

____

____

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

____

____

Does the child have any of the following habits?

Y N Lip Sucking / Biting　　Y N Nail Biting

Y N Nursing / Bottle Habits　　Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain ________________________________

____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N Allergies to any Drugs

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Birth Defects

Y N Convulsions/Epilepsy

Y N Pregnancy

Y N Tuberculosis

Y N Handicaps/Disabilities

Y N Hearing Impairment

Y N Heart Disease/Murmur

Y N Hemophilia/Blood Disorders

Y N Hepatitis

Y N HIV + / AIDS

Y N Kidney/Liver Conditions

Y N Rheumatic/Scarlet Fever

Y N Allergies to Latex Product

Y N Diabetes

Please discuss any serious medical conditions the child has had

____

____

Please list all drugs the child is currently taking _______________

____

Please list all drugs the child is allergic to ___________________

____

Child's Physician ___________________________________

Phone (_____________)_____________________________

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good　**Fair**　**Poor**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11.

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.

_______________________________________　　______________________________

Signature of Parent or Guardian　　Date　　Relationship to Patient

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

We at Sea Of Smiles look forward to providing excellent dental care to your child. Our commitment to your child's dental health is of the highest regard. The following information is the office financial policy. This is a required form of our office and we do require the parent/ guardian to read, understand and agree to the following information, your signature is required in order to be an established patient in our office.

Do you have Insurance?
As a courtesy we will help you process all your insurance claims for the insurance companies we are providers for. We do file for ***ONE*** insurance company, your primary policy. (*If you have a secondary, you must file your own claim after the primary pays the in initial claim)* We can also offer a pre- estimate of benefits with the information your insurance company provides us when we verify your insurance. If you change your insurance or if your insurance company changes coverage, it is **YOUR** responsibility to notify us with this information.

We do accept: Cash, Check, Visa, MasterCard, Discover, American Express and Care Credit. We do offer a ***CASH*** discount, if you pay by CASH only at time of procedure. Please Note: We do have a **RETURN** check fee and a collection fee if we have to submit your account to our collection agency.

All charges you incur are your responsibility regardless of your insurance coverage. As a dental care provider our relationship is with you, our patient, not the insurance company. Your insurance policy is a contract between you and the insurance company. Our office is not part of that contract.

Insurance payments are usually received in 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask you to contact them to make sure payment is expected. If payment is not received or denied, you will be responsible for paying the full amount at that time. We will cooperate with the regulations and requests of your insurance company with information for payment of claim; however we will not enter into a dispute with your insurance company over any claim.

We ask that you pay the deducible and any co- payments, which is the estimated amount not covered by your insurance company at the time of your child's dental visit.

We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office (assignment of benefits provider).

I HAVE READ AND UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS**, I authorize my Insurance Company to pay my dental benefits directly to Sea Of Smiles/ Dr. Lisa LaPresti, D.M.D.** I understand that the responsibility for the payment for dental services provided in this office for my dependents is mine, due and payable at the time service is rendered. I understand that a finance, rebilling, collection charge and/or attorney fee will be added to my overdue balance.

Name: ____Relationship to patient:________________

Signature: ____ Date:_______________________________

Sea of Smiles, Inc.

PATIENT CONSENT FORM
(HIPAA)

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my entire medical record which contains protected health information to carry out:

- Treatment (including direct or indirect treatment by other providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operation of your practice in accordance with your notice of privacy practices.

I have been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under(HIPAA). I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment; payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this___________________ day of________________________, 20________

Print Name: ____

Relationship to Patient: ____

Signature: ____

Sea of Smiles, Inc.

Pediatric Dentistry consent for dental procedure and acknowledgement of receipt of information

State law requires us to obtain your consent for your child's contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.

I hereby authorize and direct Dr. Lisa LaPresti, assisted by other dental auxiliaries of her choice, to perform upon my child (or legal ward for whom I am empowered to consent) the following checked dental treatment or oral surgery procedures:

__ Radiographs (x-rays) of the teeth and jaws
__ Cleaning of the teeth and application of topical fluoride
__ Application of plastic "sealants" to the grooves of the teeth
__ Use of local anesthesia to numb the teeth and tissues
__ Treatment of diseased or injured teeth with dental restoration (fillings)
__ Replacement of missing teeth with dental prosthesis
__Removal (extraction) of one or more teeth
__ Treatment of diseased or injured oral tissues (hard and/or soft)
__ Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
__ Use of sedative drugs to control apprehension and/or disruptive behavior
__ Other: ____

The nature and purpose of the treatment and procedures have been explained to me in general terms by Dr. Lisa LaPresti. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, the risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to cure. I further authorize the doctor to perform other dental services that in her judgment are advisable for my child or legal ward, with the exception of (if none, so state):____ I also authorize Dr. LaPresti to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications. Although their occurrence is not frequent, some risks and complications are known to be associated with dental or oral surgery procedures. The most common complications associated with pediatric dental treatment include nausea following the administration of local anesthesia. Less common complications include the risks of numbness, infection, swelling, prolonged bleeding, discoloration, vomiting, allergic reactions, swallowing or aspiration of a crown form, an extracted tooth or gauze padding, injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), injury to nerves near the treatment site and fracture of a tooth root which may require additional surgery for its removal. For children with heart disease the risk of subacute bacterial endocarditis (heart infection) following dental treatment exists; therefore antibiotics will be prescribed before and following treatment to minimize risk. I further understand and accept that complications may require additional medical, dental, or surgical treatment and may require hospitalization and may even result in death. Dr LaPresti discussed with me, to my satisfaction, these complications. The complications have been explained to me, to my satisfaction along with possible alternative methods and their advantages and disadvantages; the risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided. I hereby state that I have read and understand this consent form, that I have been given and an opportunity to ask questions that I might have and, that all questions about the procedure(s) have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to my questions which may arise during the course of my child's treatment. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

Patient Name____
Signature of Parent or Legal Guardian____
Relationship to Patient____
Time____ Date____
Signature of Dentist____

Sea Of Smiles, Inc.

Appointment & No Show Policies

It is our dedication to provide timely care to all of our patients. We will make every effort to accommodate your schedule, but in return we need your help in keeping your appointments and arriving on time.

In order to be respectful of the dental needs of other patients, please be courteous and call the office promptly if you are not able to keep your scheduled appointment. This time can be offered to another patient who may have an urgent matter.

Check – In Policy

All **NEW** patients are asked **to arrive 15 minutes prior** to their scheduled appointment time, in order to complete the required forms to become established with the dental office. We may ask **existing patients to arrive 10-15 minutes prior to their dental visit to update their dental forms.** These forms are available on our website, if you care to print them out prior to your child's appointment, just fill them out and bring them to the dental visit.

Late Policy

If you are running late, please contact the office. We will evaluate whether or not your appointment will need to be rescheduled.

If you arrive more than 10 minutes late to your scheduled appointment, we will make an effort to accommodate you. However, your appointment may be rescheduled.

_________________(INITIALS)

NO SHOW POLICY

A **No Show Fee of $35.00** may be applied to your account for missed appointments or a Cancellation less than 24 hours prior to your child's appointment.

________________(INITIALS)

Last minute cancellations will be evaluated on a case by case basis and may be considered a No Show at the Dentist's and /or Office Manager's discretion.

Parent Observation Agreement

While we welcome a parent to accompany their child into the treatment room, we kindly ask that you follow certain guidelines to ensure that we can provide the best possible experience for your child:

**We permit ONE parent to accompany their child for restorative procedures (fillings, crowns, extractions, etc.). Our space is very limited and too many people can be overwhelming for the patient, staff and doctor.*

**Please try to be a "silent observer" during restorative procedures. We understand that parents can be a great source of emotional support to their child during treatment; however, we want to make sure that we have your child's full attention to ensure the highest quality of care.*

**We do not permit additional children/siblings in the operatory at any time. If you do have siblings with you, you will be asked to wait in the lobby during treatment. Also, children not being seen cannot be left in the lobby unattended.*

**We ask that you remain seated in the chair assigned to you during treatment.*

**NO pictures or video recording is permitted during treatment.*

We would like to thank you for entrusting us with your child's dental care and we look forward to a great visit!

Parent Signature: ________________________ Date: ____________