POLAR PEDIATRIC
DENTAL CARE

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Welcome to the Polar Pediatric Dental Care Family!

We are so excited that you chose our practice for your little one(s). Our team wants to let you know some of the extra-special benefits you have as a patient of our practice.

- We offer before and after school appointments. Our office opens at 7:30am and offers appointments through the early evening.
- Dr. Westover is available to your family 24 hours a day 7 days a week.
- We text! Do you have a question, need to reschedule, or make an appointment? Text us!
- We offer text and email statements. One click and you can view your statement wherever you are. You can pay with one click too.
- Our office cares about your child's *overall* health.
    - Dr. Westover has completed additional training in tongue-tie and release. Did you know it can affect your child's digestion?
    - At every check-up appointment Dr. Westover completes an orthodontic evaluation to determine when your child should or seek orthodontic treatment.
- Our team, not just the doctor, are specialists in pediatric dental care. The team has a combined 50+ years of pediatric dental experience.

Have any other questions? Give us a call, email or text! Our front desk team is happy to help answer any questions that you may have.

Please let us know if we can make any special accommodations for you or your child to make him/her feel more comfortable for their first visit.

Kindest Regards,

Dr. Westover and Team

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New Patient Information

Date _____

In order to get to know your family better, and to provide you with the best service, we ask that you provide us with some information. Please fill out this form to the best of your ability. Thank You.

Patient's Name _____ Preferred Name _____

School: _____ SSN: _____

Age _____ Date of Birth _____ Ethnicity _____ Sex _____

Whom (or what) may we thank for referring you to our office? _____

What is the reason for your visit? (cleaning, tooth ache, etc.) _____

Names and ages of siblings at Polar Pediatric Dental Care: _____

Family History

☐ Mother's / ☐ Guardian's
Complete Name _____ Date of Birth _____

Home Address _____ City _____ State _____

Home Phone _____ DL / ID # _____ Zip _____

Cell Phone _____ SS# _____

Email Address _____

Name of Employer _____ Phone _____

Work Address _____ City _____ State _____ Zip _____

☐ Father's / ☐ Guardian's
Complete Name _____ Date of Birth _____

Home Address _____ City _____ State _____

Home Phone _____ DL / ID # _____ Zip _____

Cell Phone _____ SS# _____

Email Address _____

Name of Employer _____ Phone _____

Work Address _____ City _____ State _____ Zip _____

Patient's Parents are: ☐ Together ☐ Divorced ☐ Separated
Other: _____

Emergency Contact

Emergency Contact _____ Phone _____

Address _____ City _____ State _____ Zip _____

Medical Information

Physician _____ Phone _____ Date of Last Exam _____

Does your child have / or had:	YES	NO		YES	NO
Birth Defect	☐	☐	Eye Disorder	☐	☐
Cleft Lip / Palate	☐	☐	Hearing Problems	☐	☐
Difficulty with Speech	☐	☐	Kidney Disease	☐	☐
Asthma	☐	☐	Cystic Fibrosis	☐	☐
Blood Transfusion	☐	☐	Tuberculosis	☐	☐
Emotional Disorder	☐	☐	Developmental Disorder / Delay	☐	☐
Diabetes	☐	☐	Thyroid or Endocrine Disorder	☐	☐
Heart Disease	☐	☐	Heart Murmur	☐	☐
Hepatitis or Liver Disease	☐	☐	Rheumatic Fever	☐	☐
Neurological Disorder	☐	☐	Epilepsy or Seizures	☐	☐
Anemia	☐	☐	History of or currently being breast fed	☐	☐
HIV Positive	☐	☐	History of or currently taking a bottle at night	☐	☐
Autism	☐	☐	History of or currently thumb / finger sucking	☐	☐
ADD / ADHD	☐	☐	History of or currently have headaches, ear aches, ear wax, gas, bloating, or burping, acid reflux	☐	☐
Cancer	☐	☐	History or current use of a pacifier	☐	☐
Bleeding Disorder	☐	☐	History of injury to the Mouth	☐	☐
Unfavorable dental visits in the past?	☐	☐	Other _____		

If you answered “yes” to any of the above, please specify

Please list any known allergies (medicines, foods, latex, etc.)

Is the patient currently taking any medications (include over the counter medications)

Please list hospitalizations and surgeries with dates

Patient's Dental History

Date of last visit: _____ What procedure(s) were performed? _____

Previous Dentist _____ Phone _____

How often does the patient brush? _____ How often does the patient flos _____

Home Water Supply: ☐ Well ☐ City ☐ Bottled

Insurance

Primary Name _____ Relationship to Patient _____

Member ID _____ Date of Birth _____ Group Number _____

Insurance Company _____ Insurance Phone _____

Secondary Name _____ Relationship to Patient _____

Member ID _____ Date of Birth _____ Group Number _____

Insurance Company _____ Insurance Phone _____

Please read and sign to have our office file your insurance benefits.
I authorize the release of information and understand that I am responsible for all costs of dental treatment.

_____ _____

Signature of Patient, Parent, or Guardian Date

Responsible Party

Polar Pediatric Dental Care understands there are times a parent or guardian is unable to bring a child in for scheduled appointments or emergencies. You may give permission for others to bring in your child if you list them below. Only parents, legal guardians, or those listed below can consent for treatment for your child.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

General Consent for Treatment
I hereby authorize and direct Polar Pediatric Dental Care to perform upon my child (or legal ward for whom I am empowered to consent) the following dental procedure(s):

Examinations & radiographs
I understand that the initial visit may require radiographs in order to complete the examination, diagnosis and treatment plan. I understand the doctor will perform an examination, resulting in her diagnosis and a treatment plan. Radiographs will be taken only when there is a clinical need to do so. There may be a clinical need for radiographs every 6 months and occasionally more often for patients at high risk of decay or with conditions that require frequent monitoring. _____ Initial

Dental Prophylaxis (cleaning)
I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums. It is limited to the removal of plaque, extremely light build-up and stains from tooth structures in the absence of periodontal (gum) disease. This treatment helps to minimize gingivitis. Cleanings may be completed using a toothbrush and polishing paste in young patients that are not yet able to cooperate for the rotary rubber cup polisher. _____ Initial

Application of topical fluoride
Fluoride treatments are typically performed as part of dental cleanings every six months. In certain situations they may be recommended more frequently. Fluoride helps to prevent and slow the process of dental decay and can also improve symptoms of sensitivity by strengthening enamel. _____ Initial

Behavior Management
"Mouth pillows" or "mouth props" can make holding the mouth open more comfortable during dental procedures. If patients do not wish to use them they will not be utilized unless the dental treatment is emergent. I consent to their use during all dental restorative procedures and sealants.

Every effort will be made to ensure your child has a positive experience during each visit. I understand that my child will not be restrained to complete dental treatment unless there is an emergent need to do so.

During the course of the visit, if your child is not cooperative for the examination or cleaning, we may ask you to hold your child so the doctor can perform the examination or cleaning. _____ Initial

Local anesthesia
I understand that local anesthesia will sometimes be used to numb the teeth and tissues if dental fillings/crowns/extractions are necessary. Local anesthetics are very safe medications, but as with any medications there are risks. Common side effects include discomfort at the injection site and chance of injury to oral tissues due to loss of sensation while numb. Uncommon risks include allergic reaction, nerve damage, and infection - which may require medical treatment and hospitalization.
_____ Initial

Changes in treatment plan
I understand that during dental treatment, it may be necessary to change or add procedures. The most common change is the additional need for primary tooth nerve treatment or addition of a crown instead of a filling. I give my permission to Polar Pediatric Dental Care to make changes and additions as necessary and understand that I will be informed of such changes. Said changes may impact my financial responsibility. _____ Initial

Dental insurance benefits
I understand that my dental insurance may not provide coverage for all recommended procedures. I further understand that it is my responsibility to know my insurance plan's limitation and payment provisions, including maximums, deductibles, exclusion, benefit year, etc. Polar Pediatric Dental Care will verify my dental benefits and file my insurance claims as a courtesy, but understanding that the limitations and covered service under my policy is ultimately my responsibly. Deductibles and co-payments are due at the time of service. I assign all insurance benefits payable to Polar Pediatric Dental Care. I understand that if the insurance company does not receive payment for services within 45 days of the date of service the balance will be turned over to me. _____ Initial

Text message and email notifications
I authorize Polar Pediatric Dental Care to use the mobile number I provide and or email address, to send me appointment reminders and past due notifications for prophylaxis (cleaning) and exam, and unscheduled treatment. If I do not wish to receive reminders via text or email I may request this in writing to the office to call an alternate number. _____ Initial

Notice of privacy practice
I have received a copy of the Polar Pediatric Dental Care offices notice of privacy practices. _____ Initial

Cancellation policy
We are a small office that designates specific time for your child's appointment. We understand that sickness and emergencies may keep you from attending a scheduled appointment and ask that you provide our office with at least **24 hours advance notice or you may be charged a $35 cancellation fee.** We will try to reschedule your child's appointment at a more convenient time. Please understand the best appointment times are difficult to obtain with short notice. _____ Initial

I understand that the information that I have given is correct to the best of my knowledge, that it will held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status and any changes to insurance. In the absence of a legal guardian, the person bringing this patient is hereby authorized to approve. I also authorize the dental staff to perform the necessary dental service that my child may need.

_____ _____
Signature of Patient, Parent, or Guardian Date

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Financial Consent

Patient's Name _____ Patient's Date of Birth _____

Financial Agreement

Thank you for choosing Polar Pediatric Dental Care as your child's dental care provider. We are committed to providing the best dental care possible for your child. An important part of providing excellent dental care is making the cost manageable for our patients. The following statement explains our Financial Policy, which we ask that you read and sign.

Payment or Co-Payment is due at the time of service. We accept cash, checks, Visa, MasterCard and Discover.

Insurance
For patients with dental benefits, Polar Pediatric Dental Care is happy to work with carriers to maximize benefits and directly bill the carrier for reimbursement of treatment. However, if Polar Pediatric Dental Care does not receive payment from the carrier within 45 days of the date of service, you will be responsible for payment of the treatment fees. Polar Pediatric Dental Care will do its best when estimating fees which will be due from the patient for procedures, however, by signing below, the patient acknowledges that they are responsible for any amount due and owing Polar Pediatric Dental Care which is not covered by benefits, no matter the estimate given at the time of service. _____ Initial

If insurance will not pay all or part of the fees for treatment, or the insurance is discontinued for any reason, the patient is responsible for the unpaid portion of our treatment fees. _____ Initial

Polar Pediatric Dental Care and it's providers do not participate (out-of-network) with any Medicaid plans and therefore will not submit claims to those plans _____ Initial

Collections
All accounts which become 30 days delinquent are subject to a $25 service charge per month on the past due amount. In the event of non-payment of dental services, Polar Pediatric Dental Care may seek remedy through the legal process. You agree to the reasonableness of such remedies, and agree to bear the burden of such collection costs including but not limited to, collection agency fees, attorney fees, court costs, and filing fees. _____ Initial

Returned Checks
A $35 fee is charged to patients for returned checks. Payment will need to be made by cash, credit card, or cashier's check within 14 days. _____ Initial

The responsibility for payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of our office. _____ Initial

Patient Acknowledgement
I have read and understand the Financial Polices of Polar Pediatric Dental Care.

_____ _____
Signature of Patient, Parent, or Guardian Date

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been given a copy of the Notice of Privacy Practices for Polar Pediatric Dental Care. This notice describes how my or my child's health information will be used and shared. I understand Polar Pediatric Dental Care has the right to change this notice at any time and that I may obtain a current copy upon request.

This information permits Polar Pediatric Dental Care to use and/or disclose health information relating to my or my child's dental treatment in this office.

I have read and acknowledge the HIPAA notice for:

_____
Patient's Name

_____ _____
Guardian Signature **Date**

_____

Printed Name

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PRIVACY NOTICE

This notice is required by the new patient privacy regulations issued by the United States Department of Health and Human Services (HHS) and describes how your medical information may be used or disclosed and how you may gain access to your medical information.

Your protected health information (i.e. individually identifiable information such names, dates, phone/fax numbers, email addresses and demographic data) may be used or disclosed by us in one or more of the following respects:

- To other healthcare providers (i.e. your general dentist, oral surgeon, hospital, etc.) in connection with our rendering treatment to you.
- To third party payors or spouses (i.e. insurance companies, employers with direct reimbursement, administrators of flexible spending accounts, etc.) in order to obtain payment of your account.
- To certifying, licensing and accrediting bodies (i.e. state dental boards, the American Board of Orthodontics, etc.) in connection with obtaining certification, licensure or accreditation.
- Internally, to all staff members who have any role in your treatment.
- To other patients and third parties who may overhear conversations about your treatment, scheduling, etc.

Under the new privacy rules, you have the right to the following:

- Request restrictions on the use and disclosure of your protected health information.
- Request confidential communication of your protected health information.
- Inspect and obtain copies of your protected health information through asking us.
- Amend or modify your protected health information.
- Receive an accounting of certain disclosures made by us of your protected health information.
- You may file a complaint with the HHS Secretary as to any violation by us of your privacy rights, which must be filed within 180 days of the violation.

We have the following duties under the privacy rules:

- To only utilize your protected health information as set forth in the attached Consent and/or Authorization.
- To obtain your written consent to use your protected patient information for treatment, payment or health care operations, and to refuse treatment if you refuse treatment to sign the consent.
- To obtain your written authorization to use your protected patient information for any purpose other than treatment, payment or health care operations.
- To use reasonable efforts to limit the amount of protected health information that is used, disclosed or requested to the minimum degree necessary where such information is used, disclosed or requested for purposes other than treatment.
- To obtain satisfactory assurances from our business associates who render services to our office that your protected health information will be safeguarded by them.

Please note that we are <u>not</u> obligated to:

- Honor any request by you to restrict the use or disclosure of your protected health information.
- Amend your protected health information if, for example, it is accurate and complete.
- Provide an atmosphere that is totally free of the possibility that your protected health information may be overheard by other patients and third parties.

If you have any questions about the information in this notice, please let us know.

Polar Pediatric Dental Care
Laura Westover, DDS, MS