Tomer Haik, D.D.S., P.A.

Specializing in Dentistry for Infants, Children, and Adolescents

3319 State Road 7, Suite 213, Wellington, Florida 33449 Phone: 561-333-8441 Fax: 561-333-8507 www.young-smiles.com

OFFICE POLICIES

Thank you for giving us the privilege of serving your child's dental health needs. Because we value our relationship with you and believe that the best relationships are based on understanding, we offer these clarifications of our office policies:

Parent Information

We invite you to stay with your child during the initial examination as this will give you an opportunity to see the staff in action and allow the doctor to discuss dental findings and treatment directly with you. During future appointments, we suggest you allow your child to accompany our staff through the dental experience. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome apprehension, and we are all highly experienced in helping children overcome anxiety. Separation anxiety is not uncommon in children, so please try not to be concerned if your child exhibits some negative behavior. This is normal and will soon diminish. Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own and in an environment designed for children. It is our goal to make each and every visit to our office a pleasant one!

Disclosure

Our office believes in utilizing an open friendly environment to make your child feel welcome. In doing so, we will often display your child's name in our office. Examples of this include our Welcome Board, our Cavity Free Club, and our daily schedules. Every effort is made to keep information to a minimum.

Appointment Policy

If your child is under the age of 6, we ask that you schedule a morning appointment. In our experience, we have found that younger children tend to do better when they are well rested.

If you cannot keep an appointment, please give a 24 hours notice, as our other patients will appreciate your courtesy in releasing this time for them. If this is not given, a $50 fee will be charged to your account. If there are three broken appointments within your family, we have the right to dismiss you from our practice. Since appointment times are reserved exclusively for each patient, we reserve the right to reschedule a patient if not present 15 minutes into scheduled time.

As a courtesy, our office will contact you to remind you of upcoming appointments via mail, telephone, e-mail, and/or text messaging.

Infection Control

We utilize the most effective infection control measures and fully comply with the new OSHA standards for sterilization. We maximize our use of disposable materials and autoclave all of our hand instruments.

We encourage you to ask any questions you may have throughout your visit.

I have read and understand the Office Policies and agree to abide by its contents:

____________________	____________	____________________
Signature of Parent or Guardian	Date	Relationship to Patient

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PATIENT INFORMATION

Thank you for giving us the privilege of serving your child's dental health needs. We are committed to providing the best possible care. Complete and thorough answers to the following questions will help make this possible. Thanks again for your cooperation.

PLEASE USE BLUE OR BLACK INK TO COMPLETE THIS FORM.

PATIENT'S INFORMATION

Today's Date: ______________________________

Siblings that we treat: ______________________________

Child's Name: ______________________________

Child's Home Telephone: _(_____)______________________________

Date of Birth: ____________________ Gender: ☐Male ☐Female

Child's Home Address: ______________________________

____

Nickname (if any): ______________________________

Child's School: __________________________Grade: _________

SS#: ______________________________

Who may we thank for referring you to our office? ______________________________

MOTHER'S INFORMATION

Name: ______________________________

Employer: ______________________________

Date of Birth: ______________________________

Home Telephone #: (_______)______________________________

Circle one: MOTHER STEPMOTHER GUARDIAN

Cellular Phone #: (_______)______________________________

SS #: ______________________________

Work Telephone #: (_______)____________________ Ext. __________

DL#: ______________________________

FATHER'S INFORMATION

Name: ______________________________

Employer: ______________________________

Date of Birth: ______________________________

Home Telephone #: (_______)______________________________

Circle one: FATHER STEPFATHER GUARDIAN

Cellular Phone #: (_______)______________________________

SS #: ______________________________

Work Telephone #: (_______)____________________ Ext. __________

DL#: ______________________________

Who is Accompanying the Child Today?

Name: ______________________________ Relationship: ______________________________ Do you have legal custody of this child? ☐YES ☐ NO

PERSON RESPONSIBLE FOR ACCOUNT

Name: ______________________________

Home Telephone #: (_______)______________________________

Relationship: ______________________________

Cellular Phone #: (_______)______________________________

Billing Address: ______________________________

Work Telephone #: (_______)______________________ Ext. ________

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E-Mail: ______________________________

PRIMARY DENTAL INSURANCE

Insurance Co. Name: ______________________________

Policy Owner's Name: ______________________________

Insurance Co. Address: ______________________________

Relationship to Patient: ______________________________

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Policy Owner's Date of Birth: ______________________________

Insurance Co. Phone #: (_______)______________________________

SS#: ______________________________

Group # (Plan, Local, or Police #): ______________________________

Policy Owner's Employer: ______________________________

Please inform us if there is a secondary dental insurance.

This is to certify that I, the undersigned, authorize my insurance to pay directly to Tomer Haik, DDS, PA. I understand that Tomer Haik, DDS, PA will process all claims to my insurance carrier as a courtesy to me. I understand that all insurance policies are different and I am responsible for knowing my plan provisions, and I will be responsible for all co-payments, deductibles, and rejected charges as set by my insurance.

______________________________ Signature of Parent or Guardian

______________________________ Date

______________________________ Relationship to Patient

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PATIENT HEALTH HISTORY

Name of child's Physician: ______________________ Date of last physical exam: ______________

Please describe the child's current physical health: ☐Good ☐Fair ☐Poor

☐YES ☐NO Is your child currently under the care of a physician? If so, why? ______________

☐YES ☐NO Has your child ever had a health problem? ______________

☐YES ☐NO Has your child ever been hospitalized? Emergency room? ______________

☐YES ☐NO Are your child's immunizations up-to-date? ______________

☐YES ☐NO Has your child had any operations? ______________

☐YES ☐NO Is your child currently taking any medications? (please give name of medication, dose, and reason)

____

☐YES ☐NO Did your child experience any complications at birth? ______________

☐YES ☐NO Does your child have any allergies to any Medications, Foods, and/or Latex? ______________

____

Has your child ever been diagnosed and/or treated for any of the following: (Please check all that apply)

☐ HIV/AIDS	☐ Diabetes	☐ Hepatitis	☐ Tuberculosis	☐ Mental Delays
☐ Anemia	☐ Epilepsy/Seizures	☐ Kidney Disease	☐ Congenital Birth Defects	☐ Physical Delays
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Cerebral Palsy	☐ Social Delays
☐ Blood Disorder Transfusion	☐ Frequent Headaches	☐ Rheumatic Fever	☐ Cleft Lip/Palate	☐ Speech/Hearing Problems
☐ Cancer/Tumors	☐ Heart Condition/Murmur	☐ Stomach/GI Disease	☐ Frequent Infections	☐ Other

Explain ______________

PATIENT DENTAL HISTORY

What is the reason for your child's dental visit today? ______________

____

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 ______________

____

Is your child's water fluoridated? ☐YES ☐NO

Is your child taking fluoride supplements? ☐YES ☐NO

Does your child brush his/her teeth daily? ☐YES ☐NO

Does your child Floss his/her teeth daily? ☐YES ☐NO

Has your child ever had any pain or tenderness, or clicking in his/her jaw joint? (TMJ/TMD) ______________

Do you think your child will react well to dental treatment? ☐YES ☐NO

Explain ______________

Has your child ever had a serious or difficult problem associated with previous dental work? ______________

Does your child have any of the following habits?

☐YES ☐NO Lip Sucking/Biting
☐YES ☐NO Nail Biting
☐YES ☐NO Nursing/Bottle Habits
☐YES ☐NO Thumb/Finger Habits

CONSENT FOR DENTAL TREATMENT

This is to certify that I, the undersigned, have filled out the above information honestly and to the best of my knowledge, and I understand 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 request and authorize Dr. Haik and his staff to examine, clean and provide my child with comprehensive dental treatment including fillings, crowns, extractions and nitrous oxide inhalation, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Haik to diagnose and/or treat my child's dental condition. I allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Haik will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tones. I understand that I will be responsible for any charges incurred on this child for dental treatment.

______________ Signature of Parent or Guardian ______________ Date ______________ Relationship to Patient

DOCTOR'S NOTES:
I verbally reviewed the medical/dental information above with the Parent/guardian and patient named herein.

Initials ______________ Date ______________

Doctor's Comments ______________

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FINANCIAL POLICY

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. We ask that you pay the cost of all treatment rendered as set by our office or by your insurance carrier on the day of that appointment. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following alternatives are listed as a guide for possible financial arrangements: ***(PLEASE INITIAL EACH ITEM AND SIGN AT THE BOTTOM).***

1. **Payment is due in full** for each appointment as services are rendered. We accept cash, personal checks, MasterCard, Visa, American Express, Discover, and CareCredit. A charge of $30 will be assessed on checks returned for any reason and for declined credit card transactions assigned for payment plans. Please note that all delinquent accounts will be pursued by a collection firm. Any accounts handled by a collection firm will accrue an additional 35% to 50% of the remaining balance amount.

   ____________ Initials

2. **Dental Insurance:** Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits. Tomer Haik, DDS, PA, has no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. As a courtesy to you, our office will process all claims to your insurance carrier. Please note that all insurance policies are different and it is your responsibility to know your plan provisions.

   ____________ Initials

3. **Limitations Set By Insurance Companies:** Please note that some insurance companies only cover certain dental procedures based on a time schedule (for instance, some insurance companies cover certain x-rays only once in a 12 month period, or topical fluoride treatment once in a 12 month period). Do not misinterpret these limitations as your recommended treatment**. Dr. Haik will recommend the best necessary treatment for your child regardless of your insurance limitations. It is your responsibility to be aware of these limitations and your financial responsibility.**

   ____________ Initials

4. **Fillings:** Our dental material of choice is a white (composite resin) filling. Please be advised that your insurance company may not pay for a resin filling at the same level as a silver (amalgam) filling. The co-payment is your responsibility.

   ____________ Initials

5. **Nitrous Oxide (Laughing Gas):** Nitrous oxide is routinely used to reduce anxiety and apprehension among young children. It not always covered by dental insurance.

   ____________ Initials

6. **Appliances:** The entire cost of an appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory fees when appliances are ordered, not when completed.

   ____________ Initials

7. **Emergency Treatment:** For first time patients presenting for emergency treatment, accounts must be paid in full at the time the service is rendered. Please remember, even if you have insurance coverage, you are responsible for payment of your account.

   ____________ Initials

8. **Behavior Guidance:** In some instances, some children require additional time and attention to guide them properly to a greater level of understanding and comfort at the dental office in order to achieve comprehensive dental care. Behavior Guidance is not always covered by dental insurance.

   ____________ Initials

I have read and understand my obligation.

______________________________	____________	____________________	______________________
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, ____________________________, have received the Notice of Privacy Practices
Parent or Guardian's Name

for my child______________________.
Patient's Name

____________________________________ ________________________ ____________________
Parent or Guardian Signature Relationship to Patient Date

For Office Use Only

We attempted to obtain a written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

□ Individual refused to sign
□Communication barriers prohibited obtaining the acknowledgement
□An emergency situation prevented us from obtaining acknowledgement
□Other (Please Specify)

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