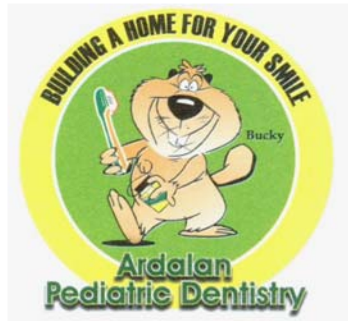

Reza Ardalan, DMD

Welcome to Our Practice!

Office Policies

We'd like to thank you for allowing us to provide dental care for your child. 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.

We strive to make each and every visit to our office a fun 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, No Cavity Club board and our daily schedules. We may also take photographs of your child for educational/promotional purposes. 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 48 hours notice. If this is not given, a $25 fee will be charged. If there are three broken appointments within your family we have the right to dismiss you from our practice. Since appointed times are reserved exclusively for each patient, we reserve the right to reschedule a patient if not present 15 minutes into scheduled time.

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. Any questions you have are welcomed!!

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

Parent/Guardian:________________________________ Date:_______________

Ardalan Pediatric Dentistry
374 SW Prima Vista Blvd.
Port Saint Lucie, Florida 34983
www.ArdalanDental.com
Phone: 772.344.4664 Fax: 772.621.4498

PATIENT INFORMATION

Child's Name: ______________________ Date: __________

Name child would like to be called: ______________ Birth Date: __________ Gender: __________

Address: ____

____

Phone (Home): ______________ (Work): ______________ (Cellular): ______________

School: ______________________________________ Grade: __________

Names of other children in the family: ______________________________

Mother's Name: ______________________ Mother's Employer: ______________________

Social Security #: ______________________ Birth Date: ______________________

Father: ______________________ Father's Employer: ______________________

Social Security #: ______________________ Birth Date: ______________________

Who has legal custody of patient? ______________________________

Whom may we thank for referring you to our practice: ______________________________

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

HEALTH HISTORY

☐ Yes ☐ No Is your child in good health? Name of child's physician: ______________________
Physician's Phone Number: ______________________
Date of last physical exam: ______________________

☐ Yes ☐ No Has your child ever had a health problem? ______________________

☐ 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 medication, doses, and reason: ______________________

____

☐ Yes ☐ No Were there any problems at birth? ______________________

☐ Yes ☐ No Is your child allergic to anything? ______________________

Please check if your child has been diagnosed and/or treated for any of the following:

☐ AIDS/HIV	☐ 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

Do you consider your child to be: ☐ Advanced in the learning process
☐ Progressing normally
☐ Slow in the learning process

Was your child: ☐ breast fed ☐ bottle fed At what age was it stopped? ______________________

DENTAL HISTORY

☐ Yes ☐ No Has your child ever been to the dentist? Date of Last Dental Visit: ______________________

Name of dentist: ______________________

☐ Yes ☐ No Has your child ever had dental x-rays? Date: ______________________

☐ Yes ☐ No Do you think your child will react well to dental treatment? Explain: ______________________

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier? Age when stopped: ______________________

☐ Yes ☐ No Does your child brush his/her teeth? How often: ______________________

☐ Yes ☐ No Do you or your child use dental floss? How often: ______________________

☐ Yes ☐ No Does your child have snacks between meals? ______________________

☐ Yes ☐ No Have your child's teeth ever been injured? When: __________ Which: ______________________

Treatment: ______________________

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds? ______________________

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Toothache	☐ Sensitive Teeth
☐ Surgical Mouth Treatment	☐ Gum Infections	☐ Color of Teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: ______________________

____

____

FLUORIDE HISTORY

☐ Yes ☐ No Is your home water supply fluoridated?

☐ Yes ☐ No Does your child use a fluoride toothpaste?

☐ Yes ☐ No Does your child use a fluoride supplement? Dose: ☐ 0.25mg ☐ 0.50mg ☐ 1.00mg

☐ Yes ☐ No Do you give your child any other forms of fluoride?

What: ______________________ Amount: ______________________

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Ardalan and his staff to examine, clean and provide my child with comprehensive dental treatment including fluoride, fillings, crowns, extractions and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary for Dr. Ardalan to diagnose and/or treat my child's dental condition. I will 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. Ardalan 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 tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature: ______________________ Date: ______________________

FINANCIAL POLICY

Please be aware that the parent bringing the child to our office is responsible for payment of all charges at the time services are rendered. We cannot send statements to other persons. We ask that you pay the cost of the initial examination and any necessary dental x-rays on the day of that appointment. Please understand that financial arrangements are made directly with you. In order to insure the most accurate financial information, and for the security of our patients, we require a valid social security number or driver's license. For the convenience of our patients, the following alternatives are listed as a guide for possible financial arrangements:

1. **Payment is due in full** for each appointment for services that are rendered. Payment is required prior to patient being seen. We accept cash, Mastercard, Visa, American Express and Discover. A charge of $30.00 will be assessed on checks returned for any reason and for declined credit card transactions assigned for payment plans. In addition, Ardalan Pediatric Dentistry will **no longer accept checks**.

2. **Dental Insurance:** It is our policy to not accept assignment of benefits for dental insurance other than Cigna PPO, Delta Dental PPO, Delta Dental Premier, Dentemax and Guardian PPO. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Any reimbursements by you insurance company other than those we directly participate with should be made directly to you according to the terms of your contract with them.

3. **Pre-treatment Authorizations:** Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.

4. **Fillings:** Our dental material of choice is a white (composite resin) filling. Please be aware 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. In some cases, the dentist may recommend placing a silver crown instead of a resin filling.

5. **Nitrous Oxide (Laughing Gas):** Nitrous oxide is not always covered by dental insurance. We thank you for your payment on the date of service.

6. **Appliances:** The entire cost of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when appliances are ordered, not when they are completed. If the appliance breaks, there may be an additional fee for the associated lab costs.

7. **Emergency Treatment:** All emergency treatment 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. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping us keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping to keep your fees as low as possible. I have read and understand my obligation.

Signature: ______________________________ Date: ________________

DENTAL INSURANCE INFORMATION

Primary Policy Holder: Name: ______________________________

SS#: ______________________________

Insurance Carrier: Name: ______________________________

Phone Number: ______________________________

Group/Policy Number: ______________________________

Employer of Insured: Name: ______________________________

Patient ID Number: ______________________________

I authorize my insurance to pay directly to my dentist if my insurance plan is Cigna PPO, Delta Dental PPO, Delta Dental Premier, Dentemax and Guardian PPO. If I am covered by any other plan, I will pay in full when services are rendered. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand I will be responsible for all co-payment, deductible, and rejected charges.

Signature: ______________________________ Date: ________________

NOTICE OF PRIVACY PRACTICES - HIPAA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails and/or letters).

Patients Rights

Access: You have the right to look at or get copies of your health information. If you request copies we will charge you for each page, staff time to locate and copy the information, and postage if you want the copies mailed.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.

Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means.

Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information, you may submit a written complaint to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Ardalan.

Signature: ____ Date: _________________________