Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1) Tell Us About Your Child Today's Date:

Child's name: ________________________________ Nickname: ____________________________
Last First MI

Male ☐ Female ☐

Child's Birthdate ___/___/___ Child's Age: ________

Child's Home#: (_____) ______________ SS#:____________________

Child's Home Address:

____

____
City State Zip

2) ☐ **Mother's Information**: ☐ Step Mother ☐ Guardian

Name: __________________________________ Birthdate:___/___/___

Hm#: (___) _______________________Cell#:(___)________________

Employer: _____________________Occupation:_____________________________________

Wk# (___)_____________________SS #:__________________ DL #:________________

Email: ____

☐ **Father's Information**: ☐ Step☐her Guardian

Name: ____________________________________ Birthdate:___/___/___

Hm#:(___)_____________________ Cell#:(___)__________________

Employer:_______________________Occupation: __________________________________

Wk#(___)_____________________SS #:______________________ DL #:______________

5) Primary Dental Insurance

Insurance Co. Name: ______________________ Insurance Co. Phone #: (___) _________________

Group # (Plan, Local, or Policy#) _______________Policy Owner's Name: ____________________

Relationship to Patient: _________________Policy Owner's Birthdate: __/__/__

ID #: ____________________________Policy Owner's Employer:__________________________

I understand that the information that 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 Date

Charm Pediatric Dentistry, LLC

Patient's Name ____ Date of Birth ____________________

Medical History

Does your child currently have a health condition? **Yes / No**

If so, what condition, and for how long? ____

____

Name of Physician _________________________________ Phone ______________________ Last Visit ____________________

Medications ____

List Hospitalizations/Surgeries/ER____

Allergies to (*medications and foods*)____

Allergies to *metals/alloys/other substances*____

Does your child have severe or prolonged bleeding? **Yes / No**

Has your child ever tested positive for hepatitis? **Yes / No**

Does your child have a heart murmur? **Yes / No**

Does child need antibiotic prophylaxis prior to dental treatment for SBE Congenital Heart Issues **OR** other reasons? Yes / No

If YES, explain____

Is your child subject to nervous conditions? **Yes / No**

History of any of the following:_______Fainting__________Seizures___________Dizziness_____________Behavioral /Learning issues

Has the child had any history of, difficulty with, or diagnosis of any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	ADD/ADHD	☐	☐	Cerebral Palsy	☐	☐	HIV+/AIDS	☐	☐	Rheumatic fever
☐	☐	Anemia	☐	☐	Chicken Pox	☐	☐	Immunizations	☐	☐	Ringworm
☐	☐	Arthritis	☐	☐	Chronic Sinusitis	☐	☐	Kidney	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Developmental Delay	☐	☐	Latex allergy	☐	☐	Sex. Trans. Disease
☐	☐	Autism/PDD	☐	☐	Diabetes	☐	☐	Liver	☐	☐	Sickle cell or trait
☐	☐	Behavioral Problems	☐	☐	Epilepsy	☐	☐	Measles/Mumps	☐	☐	Thyroid
☐	☐	Bladder	☐	☐	Fainting	☐	☐	Mononucleosis	☐	☐	Tobacco/Drug Use
☐	☐	Bleeding Disorder	☐	☐	Growth Problems	☐	☐	Pregnancy (teens)	☐	☐	Tuberculosis
☐	☐	Blood Transfusions	☐	☐	Hearing	☐	☐	Previous Surgeries	☐	☐	Warts
☐	☐	Bones/Artificial Joints	☐	☐	Hearts/Heart Murmur	☐	☐	Previous Hospitalization	☐	☐	Other __________
☐	☐	Cancer	☐	☐	Hepatitis						

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told **Yes / No**

If YES, explain____

____

I will not hold my dentist, or any other members of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the staff Charm Pediatric Dentistry to perform such treatments, services, medications, local anesthesia, analgesia, and accepted behavior management techniques that may be necessary to correct any oral deficiency, abnormality, infection and/or disease. If any conditions are discovered in the course of treatment which, in the opinion of the doctors authorized by this consent, require procedures in addition to or different than those described, I also authorize the performance of these procedures. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from treatment, I consent to the taking and publication of any photographs in the course of this treatment for the purpose of advancing dental education. I certify that I have read the above consent and questions were answered to my satisfaction.

Patient's/Guardian's Signature ____ Date __________________

Dentist's Signature ____ Date ___________________

Patient's Name_______________________________________ Date of Birth____

Dental History

Is this your child's first visit to the dentist? **Yes** **No** If no, who was your child's previous Dentist ______________________________

Date of Last Visit ____

Date of Last Dental X-rays ____

Please Circle the Appropriate Answer:

Does your child receive fluoride? **Yes No** *(If yes, please circle*) **Community water** **Drops,Tabs, Vits** **Toothpaste** **Rinse**

Does child brush daily? **Yes** **No** How many times/day?________

Does child floss daily? **Yes** **No**

Has child complained about dental problems? **Yes** **No**

Has your child ever had any problem with dental treatment? **Yes** **No**

Have any cavities been noted in the past and treated? **Yes** **No**

Were any teeth (baby or permanent) removed by extraction? **Yes** **No**

Is child bottle/ breast-fed to nap or bed time? **Yes** **No** **N/A**

Any habits (thumb-sucking , digit habit, nail biting, pacifier) ? **Yes** **No**

Is there a family history of cavities? **Yes** **No** **If yes, indicate who**____

Does child pocket or hold food inside his mouth? **Yes** **No**

Is the child on a special or restricted diet? **Yes** **No** **If yes, explain**____

Does your child have a diet high in sugars and starches? **Yes** **No**

Does your child eat or drink in the middle of the night? **Yes** **No**

Does your child have excessive gag reflex? **Yes** **No**

Does your child have acid/gastric reflux? **Yes** **No**

Is the child a mouth breather? **Yes** **No**

Does your child have TMJ/jaw joint problems(popping etc.) **Yes** **No**

Does your child get cold sores, aphthous ulcers, ulcers, or canker sores? **Yes** **No**

Does your child get bleeding gums? **Yes** **No**

Does your child participate in any contact sports? **Yes** **No** **N/A**

Does your child wear mouthguards at these activities? **Yes** **No** **N/A**

Has your child ever had orthodontic treatment (braces, spacers or other appliances) **Yes** **No**

Any history of dental or facial trauma? **Yes** **No**

If yes, explain____

What are your child's favorite snacks?____

What are your child's favorite drinks?____

Who is the child's primary care taker during the day?_________________________During evening?______________________

How do you expect your child to respond to treatment? (**Please circle)** **Very well** **Fairly well** **Somewhat poor** **Poor**

Is there anything else we should know before treating your child? **Yes** **No**

If yes, explain____

____

____

I will not hold my dentist, or any other members of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the staff Charm Pediatric Dentistry to perform such treatments, services, medications, local anesthesia, analgesia, and accepted behavior management techniques that may be necessary to correct any oral deficiency, abnormality, infection and/or disease. If any conditions are discovered in the course of treatment which, in the opinion of the doctors authorized by this consent, require procedures in addition to or different than those described, I also authorize the performance of these procedures. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from treatment, I consent to the taking and publication of any photographs in the course of this treatment for the purpose of advancing dental education. I certify that I have read the above consent and questions were answered to my satisfaction.

Patient's/Guardian's Signature ____ Date _________________

Dentist's Signature ____ Date __________________

Charm Pediatric Dentistry

DENTAL INSURANCE POLICY

TO ALL OUR VALUED PARENTS AND GUARDIANS:

Charm Pediatric Dentistry accepts dental insurance as a courtesy to our patients. We must inform you that most dental insurances have yearly deductibles per family member that you are responsible to pay at the time of your child's visit.

Please be aware also, that most dental insurances do not cover any restorative work or extractions at 100% coverage. Depending on the particulars of your individual policy, you will have co-insurances payable to our office at the time of your child's visit. It is the parent's or guardian's responsibility to know the percentage coverage of your policy. We will do our best to let you know ahead of time what your amount due will be for a particular visit and we ask that you come prepared to pay at that time.

Please sign this form to acknowledge that you understand the terms of your dental insurance policy. Thank you for your cooperation.

Name(please print): ____

Signature: _____________________________________ Date: ______

Charm Pediatric Dentistry

Office Policies

Leaving the office: It is against the law to treat a child under the age of 18 years of age without the parent or guardian on the premise. Also, treatment plans are subject to change during the course of the procedure and the doctor may need to speak with you. Your availability is of the utmost importance.

Payments: Payments are **due at time of service**. If you have dental insurance we will submit your claim for you, however your coinsurance is expected at time of service. We accept cash, check & major credit cards.

No Show Policy: We have a strict "no-show" policy in place. You must call us at least **24 hours in advance** if you cannot make your appointment. <u>Anyone missing 2 appointments without giving a 24 hour minimum cancellation notice will be dismissed from the practice. All "no-shows" are subject to a $45.00 fee that is not covered by your insurance company.</u>

Continuing Care Visits: Fluoride treatments & indicated x-rays are performed every 6 months unless you tell us otherwise. We will do our best to inform you of any charges ahead of time.

Restoration appointments: Dental treatments may include sealants, white (composite) fillings, pulp treatment (root canals), crowns, bondings, and /or extractions. Please check with your insurance company prior to your visit to see what procedures are covered and whether you will have a co-pay or deductible the day the services are rendered. Our doctors develop a treatment plan to provide the BEST care for your child- not based on what is covered by your insurance company.

Referrals: Required referrals must be brought in the day of your child's appointment or the visit will be rescheduled.

Emergencies: True emergencies involve severe pain, swelling or bleeding. We will do our best to accommodate true emergencies.

Predeterminations: These are only estimates. Your insurance company will not provide us a 100% accurate fee until the work is completed and they receive your claim from us. We will try to gather as much information as we can, but please remember that insurance is a contract between you and your insurance company.

By signing this form, you acknowledge that you have received this form and adhere to the office policies of Charm Pediatric Dentistry.

____________________________________ ____________________

Signature of Parent/Guardian Date

HIPPA PRIVACY FORM

Charm Pediatric Dentistry
Yoosung Suh, D.M.D.

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 (04/14/2003), 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.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorizations: 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 of 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.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare and with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use of disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practices to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

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 reasonable 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 may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

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

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0.25 for each page, $25.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. 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 theses additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (**You must make your request in writing.)** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

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.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

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 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.

Contact Officer: Kersti Choe
Telephone: 610-277-4811
Fax: 610-277-4896
Address: 1040 DeKalb Pike., Suite 100
Blue Bell, PA 19422
E-mail: charmpedo@yahoo.com

Charm Pediatric Dentistry
Yoosung Suh, D.M.D.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our 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)

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CHARM PEDIATRIC DENTISTRY INFORMED CONSENT FORM

It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment, and to accept or refuse treatment offered to your child. Please read this informed consent carefully. Should you have any question about any of the information contained in this form, please feel free to ask and we will gladly explain it further.

PATIENT MANAGEMENT TECHNIQUES

It is the intent of our dental care delivery to be the best quality available. Providing high quality dental care to children can be difficult due to a child's behavior. **This is why we ask that you allow your child to come into their appointment room alone. We find one on one communication to be most effective. Please give our policy a chance as it is in the best interest of your child.** Every effort will be made to obtain your child's cooperation through warmth, charm, humor and understanding. When these fail, there is several behavior management technique used to eliminate or minimize disruptive behavior. These are all routinely used and accepted by the American Academy of Pediatric Dentistry. They are described below.

1. **Tell-show-do**: The dentist or assistant explains to the child what is to be done by demonstrating on a model or on the child's finger. Then the procedure is done on the patient's tooth. Praise is used to reinforce cooperative behavior.
2. **Positive reinforcement**: This technique rewards the child who displays any desirable behavior. Rewards include compliments, praise, and a pat on the arm or a prize.
3. **Voice control**: The attention of a disruptive child is gained by changing the tone or increasing the volume of the practitioner's voice.
4. **Mouth Props**: A rubber device is gently placed in the child's mouth to prevent either intentional or unintentional closure on the dentist's fingers or drill.
5. **Physical restraint by dentist/assistant**: The child is held so that he/she cannot grab a moving drill or a sharp object. It also prevents the child from grabbing the practitioner's hand while delicate work is being performed. This is for the safety of the child and to facilitate treatment.

THE FOLLOWING WILL BE USED AFTER OBTAINING CONSENT FROM THE PARENT/GUARDIAN

6. **Laughing gas**: Nitrous oxide (laughing gas) is administered to calm and soothe the patient prior to a stressful procedure. Nitrous oxide is a very safe medication that rarely causes nausea. The patient is <u>always</u> awake and <u>never</u> loses consciousness.
7. **Papoose board**: This is a restraining device to limit the patient's disruptive movement and to prevent injury. It is used only as a last resort when treatment can be accomplished no other way.

POSSIBLE RISKS ASSOCIATED WITH DENTAL PROCEDURE

Although good results are expected, some risks are known to be associated with dental procedure. These risks include but are not limited to: pain, bleeding and swelling, tooth discoloration, nausea, vomiting, hyperventilation, fainting, allergic reactions and infections, development of a temporomandibular joint disorder, temporary or permanent numbness, and/or allergic reactions.

The listed pediatric dentistry behavior management techniques have been explained to me. I understand their use, and the risks/benefits/alternative available. I have had all my questions answered and I realize I can always seek further information or revoke permission for any of these techniques.

____ ____________________

Parent/Guardian Signature Date