Smile Starters

General Dentistry for Youth

first tooth through age 20

Behavior Management Techniques and Smile Starters Office Policies

Patient Full name_____, DOB: _____

Working with younger children can be very different from working with teens and adults. Young children pose unique challenges which may make rendering treatment in a safe environment difficult. Our goal is to provide our patients with the highest quality dental care while insuring a good overall experience in the safest environment possible. Lack of cooperation (from younger children in particular) may stifle our efforts. To help achieve our goal, we may utilize the following "Behavior Management Techniques" as recognized by the American Academy of Pediatric Dentistry.

First, all efforts will be made to obtain the cooperation of dental patients by using a caring attitude, charm, warmth, humor, friendliness, and understanding.

Other methods:

1. **Tell, Show, Do: We explain what will be done. We demonstrate what will be done. We then perform the action as demonstrated.**
2. **Positive Reinforcement: We praise and reward children for following directions and cooperating! Rewards might include - verbal praise, a pat on the back, a hug, a sticker or toy.**
3. **Voice Control: Voice control is modulation of one's voice to regain the attention of a child. Voice Modulation may range from a playful to a firm tone. Voice control is not to be confused with yelling at a child which is unacceptable.**
4. **Mouth Props: Mouth props are safety devices used to stabilize the mouth in an open position. They help prevent a child from biting on sharp instruments.**
5. **Physical Restraint by the Dentist or Auxiliary: During treatment, physical movements (expected or otherwise) can be dangerous for your child. A staff member may restrain parts of the body which are moving. If an uncooperative child requires more pressure from restraint than a firm handshake, protective immobilization may be required.**
6. **Protective Immobilization and/or Nitrous Oxide: These techniques are more advanced and require individual consent for their use. If these techniques are deemed necessary a provider will speak with you.**

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1. **Your child will enter the treatment areas alone as we find this generally allows for the highest levels of cooperation. We understand you may have reservations with this policy; however our expertly trained staff of professionals will do everything to insure your child's safety and well being. Our team of professionals will personally speak with you regarding your child's care prior to and upon completion of treatment.**
2. **Please remain IN THE BUILDING while your child receives their quality dental care. In the unlikely event of an emergency we would like to locate you immediately.**
3. **We will do everything within our power to keep timely appointments. Please be patient as sometimes unforeseen circumstances such as dental emergencies may redirect our attention.**
4. **Appointment times may vary for reasons such as difficulty of treatment being rendered and level of child cooperation. Your patience is appreciated.**
5. **Please have your current enrollment card(s) available.**
6. **Payment is due when services are rendered.**
7. **We strive for a family oriented environment. Please be respectful of others and your surroundings. Avoid the use of profanity, and maintain control of your children.**
8. **Photos are often obtained for diagnostic purposes. I authorize Smile Starters to utilize these photos for teaching purposes.**

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HIPAA Acknowledgement

Dear Parent/Legal Guardian,

Thank you for bringing your child, First name:_____ Last name:_____ DOB_____ into our dental office today. The privacy of your health information is important to us. Upon arrival, you should have been offered a copy of the Smile Starters "Notice of Privacy Practices". While we do not share your information with outside firms for marketing purposes, we will as a service to our patients, provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message.

By signing this document, you are acknowledging a copy of the Smile Starters "Notice of Privacy Practices" has been made available to you. A copy of our privacy practices can also be found at www.smilestartersdental.com. You are also consenting to receive prerecorded messages, texts or emails to any contact information attached to your families' account including the phone numbers provided below. To opt out, follow the message prompts.

Once again, we thank you for allowing Smile Starters to provide your dental services today.

Sincerely,

Your Smile Starters Team

Signed By: Parent/Legal Guardian_____

Date: _____

Home Phone Number: _____

Mobile Phone Number: _____

Email: _____

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Financial Policy

Financial Policies and Federal Truth-In-Lending Statement

I certify that I am the responsible party for Patient full name _____ DOB: _____. I authorize payment of my or my child's dental benefits to be made directly to Rafael Rivera Jr., DDS PLLC d.b.a. Smile Starters.

As a condition of your treatment by this office, financial arrangements must be made in advance. Smile Starters depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. We will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, Smile Starters cannot render services on the assumption that our charges will be paid in full by an insurance company.

Smile Starters chooses not to attach a fixed rate interest to outstanding balances in an effort to help our families, but balances past 30 days are considered delinquent and may be subject to additional fees if the account is assigned for collections, I agree to pay the remaining balance plus the sum of the collection fee charged by the collection agency. I authorize the release of financially identifiable information concerning my account, including charges billed and payments made etc. to the collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to email, telephone or text me at any phone number or email address I or my family have provided to discuss matters related to this form or any appointment. Furthermore I also agree to let this office leave messages concerning appointments and/or results on my voicemail, answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements.

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I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier, another oral health provider/specialist or any related entities that require such information to be submitted.

I acknowledge that I have been given the opportunity to review and ask questions about Smile Starters "Notice of Privacy Practices", and that a copy is available 24/7 on our website at www.smilestartersdental.com

Payment Options:

For your convenience We accept Cash, Visa, Mastercard, Discover and American Express and we accept Online payments via our website *www.smilestartersdental.com*

There is a nominal charge for copies of records.

We also offer an attractive Financing options - please ask about our Recurring Payments:

- **Convenient monthly payments to help make treatment affordable**
- **No interest financing**
- **Ability to prepay for some of your services!**

By signing this document, I hereby agree to the financial policies and the federal truth-in-lending statement above.

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Parental Authority:

Dental Treatment and Emergency Care Proxy Consent

Please list the names of all the children you make healthcare decisions for at this clinic:

_____

_____

_____

_____

_____

_____

If you would like any other person to have access to your child's health information, or if someone other than yourself will be bringing the child to the clinic, please list ALL their names and relationship to the child below: (Jane Test - Grandmother, Bob Test - Uncle).

_____

_____

_____

_____

_____

_____

I,_____, authorize the persons named above to make any dental treatment and emergency care decisions necessary.

I, _____, understand that this authorization will remain in effect until I update the form and any previous versions will be null and void once signed.

I,_____, understand that Smile Starters reserves the right to cancel any appointment where the person(s) accompanying the patient are not appropriately authorized by me to do so.

I,_____, understand that it is my responsibility to update this authorization form when necessary.

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Health History

Patient's Name: First _____ Last _____

Date of birth: Month _____ Day _____ Year _____

Dental History:

What brings you to the dental office today? _____

How long since the patient's last dental visit? ☐ 6 months ☐ more than 6 months ☐ more than a year ☐ never

Does the patient have any dental pain at this time? ☐ Yes ☐ No If yes, please explain _____

How often does the patient brush? ☐ once per day ☐ twice per day ☐ sometimes ☐ never

How often does the patient floss? ☐ once per day ☐ twice per day ☐ sometimes ☐ never

Does the patient have any of the following oral habits?

Suck their finger, thumb or pacifier ☐ Nail Biting ☐ Lip Sucking ☐ Biting ☐ Grinding ☐

Is the patient breast feeding? ☐ Yes ☐ No or still on the bottle? ☐ Yes ☐ No

Has the patient experienced a history of trauma or falls involving the face or teeth? ☐ Yes ☐ No If yes, please explain _____

Medical History:

	Yes	No
Is the patient under the care of a specialist now?	☐	☐
Has the patient ever been hospitalized or had a major operation?	☐	☐
Has the patient ever had a serious head or neck injury?	☐	☐
Is the patient on a special diet?	☐	☐
Does the patient use tobacco?	☐	☐
Does the patient use controlled substances?	☐	☐
Is the patient pregnant or trying to get pregnant? If yes, how many weeks?	☐	☐

When was the patient's last checkup with their physician? ☐ within a year ☐ more than a year ☐ never

List all medications, pills or drugs currently taken _____

Please mark the boxes below if the patient is allergic to any of the following:

Aspirin ☐ Penicillin ☐ Codeine ☐ Latex ☐ Metal ☐ Sulfa ☐

Does the patient have any other allergies? Please list

_____

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Health History (Continued)

Does the patient have or have they ever had any of the following?

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Epilepsy or Seizures	☐	☐	Mental health care	☐	☐
AIDS/HIV Positive	☐	☐	Excessive Bleeding	☐	☐	Premature Birth	☐	☐
Anemia	☐	☐	Excessive thirst	☐	☐	Radiation Treatment	☐	☐
Artificial Heart Valve or Joint	☐	☐	Fainting Spells/Dizziness	☐	☐	Rheumatic Fever	☐	☐
Asthma	☐	☐	Growth Problems	☐	☐	Scarlet Fever	☐	☐
Autism/Spectrum disorder	☐	☐	Hay Fever	☐	☐	Sickle Cell Anemia or Trait	☐	☐
Birth Defects	☐	☐	Heart Attack/Failure	☐	☐	Sinus Trouble	☐	☐
Blood Disease	☐	☐	Heart Trouble/Disease	☐	☐	Stomach Problems	☐	☐
Breathing Problem	☐	☐	Heart Surgery	☐	☐	Stroke	☐	☐
Bruise Easily	☐	☐	Hearing impaired	☐	☐	Thyroid or other gland disorder	☐	☐
Cancer	☐	☐	Hemophilia	☐	☐	Tonsillitis	☐	☐
Chemotherapy	☐	☐	Hepatitis A, B or C	☐	☐	Tuberculosis	☐	☐
Chest Pain/Angina	☐	☐	Herpes	☐	☐	Tumors or Growths	☐	☐
Cold Sores/Fever Blisters	☐	☐	High Blood Pressure	☐	☐	Ulcers	☐	☐
Congenital Heart Defect	☐	☐	Hives or Rash	☐	☐	Vision impaired	☐	☐
Developmental delay	☐	☐	Kidney Problems	☐	☐	Yellow Jaundice	☐	☐
Diabetes	☐	☐	Leukemia	☐	☐	Limitations in using arms or legs	☐	☐
Drug Addiction	☐	☐	Liver Disease/Problem	☐	☐	Other	☐	☐
Easily Winded	☐	☐	Low Blood Pressure	☐	☐			
Eating Disorder	☐	☐	Lung Disease	☐	☐			

Does the patient have any other medical condition not listed above?

Comments:

X_____

Signature of Parent/Legal Guardian