Roseff
PEDIATRIC DENTISTRY

Michael Roseff, 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 examinations and procedures as an observer NOT participant, unless otherwise directed by staff or Dr. Roseff. Our goal is to gain your child's confidence, trust, and overcome any apprehension.

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 may display your child's name in our office or picture. We may also utilize electronic resources, such as our Facebook Fan Page "Roseff Pediatric Dentistry" or the informational TV in the waiting room.

Appointment Policies

AGE: If your child is under the age of 7, 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. Dr. Michael will determine when our patients "graduate" to the afternoon.

NO-SHOW: Missed appointments without 48-hour notification are considered "NO SHOW" appointments and will result in a $50.00 fee. This fee must be paid prior to being scheduled again.see policy below**

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:_____

8784 Boynton Beach Blvd., #103, Boynton Beach, FL 33472
Phone: 561.732.8333 Fax: 561.732.8375

Roseff Pediatric Dentistry

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Boynton Beach, FL 33472
Phone: 561.732.8333 Fax: 561.732.8375

Today's Date: _____

PATIENT INFORMATION

Child's Name: _____ Nickname: _____ Birth Date: _____

Gender: • Female • Male School: _____ Grade: _____

Ethnicity: • Caucasian • African American • Hispanic • Non-Hispanic • Asian • Caribbean American
• Indian • Native American • Prefer not to Answer • Other: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Phone (Home): _____ (Work): _____ (Cellular): _____

School: _____ Grade: _____

Names of siblings: _____

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? _____

Leave, send, detailed voice mails or send detailed emails: • yes • no (if no, how would you prefer our communication):

_____

Emergency Contact other than parents: _____

Relationship to child: _____ Phone: _____

Primary cell number to receive appointment reminders: • Mother • Father • Other: _____

Please list whom we may discuss treatment or dental care with other than parents: _____

_____

DENTAL INSURANCE INFORMATION

Primary Policy Holder: Name: _____ SS#: _____
Insurance Carrier Name: _____ Phone#: _____
Group/Policy Number: _____
Employer of Insured: _____
Patient ID Number: _____

Secondary Policy Holder: Name: _____ SS#: _____
Insurance Carrier Name: _____ Phone#: _____
Group/Policy Number: _____
Employer of Insured: _____
Patient ID Number: _____

I authorize my insurance to pay directly to my dentist if my insurance plan is Aetna PPO, Cigna PPO, Delta Dental PPO, Delta Dental Premier, Dentemax, Guardian PPO, Humana, MetLife PDP, Safeguard PPO & HMO, GEHA, United Concordia, Principal, Florida Blue Options (PPO & Copay), and DeCare. If I am covered by any other plan, I will pay in full prior to being seen. 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: _____

HEALTH/MEDICAL 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 is your child presently under the care of a physician? Please Explain:

_____

_____

☐ Yes ☐ No has your child ever had a health problem? Please Explain:

_____

_____

☐ 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? _____

☐ Yes ☐ No Was your child Breast Fed? If so, what age stopped?

_____

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

☐ ADD/ADHD	☐ Cancer/Tumor	☐ Eye Conditions	☐ High Blood Pressure	☐ Social Delays
☐ AIDS/HIV	☐ Chemical Dependency	☐ Females: Are you pregnant?	☐ Injury to Front Teeth	☐ Speech Impairment
☐ Anemia	☐ Chicken Pox	☐ Females: Are you taking Birth Control?	☐ Kidney Disease	☐ Stomach/GI Disease
☐ Asthma	☐ Cleft Palate/Lip	☐ Frequent Headaches	☐ Mental Delays	☐ Thyroid Disease
☐ Autism	☐ Cold Sores/ Canker Sores	☐ Frequent Infections	☐ Metallic Implant, Shunts, Pins/Rods	☐ Tonsillitis
☐ Behavioral Problems	☐ Congenital Birth Defects	☐ Frequent Urination	☐ Physical Delays	☐ Transplants, Organ (specify: _____)
☐ Bleeding Gums	☐ Developmental Delayed (Age level: ____)	☐ Hearing Impairment	☐ Premature Birth (weeks: _____)	☐ Tuberculosis
☐ Blood Disorder or Transfusion	☐ Diabetes	☐ Heart Disease	☐ Prolonged Bleeding When Cut	☐ Other: _____
☐ Bone/Joint Problems	☐ Earaches/Ear Infections	☐ Heart Murmur	☐ Psychiatric Care	☐ Other: _____

☐ Brain Injury ☐ Epilepsy/Seizure Disorder ☐ Hemophilic ☐ Rheumatic Fever ☐ Other: _____

☐ Cerebral Palsy ☐ Excessive Bleeding ☐ Hepatitis/Liver Disease ☐ Sickle Cell Disease

Is there any other health information that should be known? ☐ Yes ☐ No Please Explain:

_____

_____

_____

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? Please Explain: _____

_____

☐ Yes ☐ No Has your child had recent dental pain? Please Explain:

_____

_____

☐ Yes ☐ No Does your child have a specific dental problem that needs attention? Please Explain:

_____

_____

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

_____

☐ Yes ☐ No Does your drink from a Bottle or Sippy Cup? 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 any member of the family have excessive decay or fillings?

☐ 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 ☐ Teeth grinding/clinching

Comments:

_____

_____

_____

_____

FLUORIDE HISTORY

Does your child PRIMARILY receive (check all that applies)?

☐ Tap Water ☐ Well water ☐ Bottled Water ☐ Fluoridated Bottled Water

☐ Yes ☐ No Does your child use fluoride toothpaste?

☐ Yes ☐ No Does your child use a fluoride supplements? 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. Roseff 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. Roseff 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. Roseff 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.

I have given an accurate report of this patient's physical, mental, dental, and fluoride health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Michael J. Roseff and the staff of Roseff Pediatric Dentistry of any changes in the medical history. This authorization is valid until revoked by me in writing.

Signature: _____ Date: _____

RADIOGRAPH(S) POLICY

Radiographs are the only way to reliably view the bone, roots, attachments, interproximal areas, and under and around restorations. Radiographs provide a starting point for what conditions exist today, and what changes may occur by the patient's next appointment. Detection of harmful conditions such as cancer lesions and abscesses are often impossible without radiographs.

Our office uses the ALARA principal when taking radiographs, this means we us As Low As Reasonably Achievable levels of radiation, using digital radiology protective gowns and collars, and devise to reduce scatter and concentrate the beam into the smallest area possible.

Radiographs will of course be on an individual basis based on the needs of the patient, proximity of the teeth, caries risk, age and level of cooperation. Detecting caries early is the best way to ensure the best treatment techniques are used including preventive strategies. Once you are able to see the cavity, often it is too late to treat with minimally invasive therapy.

There will be no exceptions, if Dr. Roseff recommends radiographs, and you wish not to have them take, we will not treat your child and prefer you see another dentist.

Signature: _____ Date: _____

NO SHOW POLICY

If you do not cancel within 48 hours, this is considered a no-show/missed appointment resulting in a fee of **$50 per child. MUST be paid when making new appointment/rescheduling.**
The policy is in place, due to:

1. Limit same day cancellations
2. Prime appointment times:
    a. 8:30 am/9:15 am
    b. 3:45 pm/4:15 pm
3. Give enough time for those seeking prime appointment times
4. Accommodating our patient needs
5. To continue to keep waiting room time non-existent (no double booking)

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 of appointment. 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 at the time of appointment. Payment is required prior to patient being seen.** (We will notify parent/guardian of ESTIMATED charges prior to appointment time, and if any, refunds will be given on work not completed prior to departing office. We accept Cash, MasterCard, Visa, American Express, and Discover. A charge of $30.00 for declined credit card transactions assigned for payment plans. If multiple credit cards are used for a single payment, Roseff Pediatric Dentistry will charge a $5.00 service fee. Roseff Pediatric Dentistry will **not be accepting personal checks**.
2. **Dental Insurance:** It is our policy to not accept assignment of benefits for dental insurance other than Aetna PPO, Cigna PPO, Delta Dental PPO, Delta Dental Premier, Dentemax, Guardian PPO, Humana, MetLife PDP, Safeguard PPO & HMO, GEHA, United Concordia, Principal, Florida Blue Options (PPO & CoPay), and DeCare. 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.

FINANCIAL POLICY continued

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 colored 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 at time and 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 of service. 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: _____

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. Roseff.

Signature: _____ Date: _____