Talia Pike DMD
Pediatric Dentist

Office Policies

The office attempts to schedule appointments at your convenience and when time is available. If your child is under the age of 6, we recommend that you schedule a morning appointment for your child. Younger children are more cooperative when they are well rested.

Since appointed times are reserved exclusively for each child, we ask that you please notify our office 24 business hours in advance of your scheduled appointment time if you are unable to keep your appointment. We realize that unexpected things can occur, but we ask for your assistance in this regard. If your child misses an appointment without notifying us 24 business hours in advance, a cancellation fee will be applied to your account. This fee will vary depending on the length of time reserved for your child.

A visit to the dental office presents the young child with a lot of new and unfamiliar experiences. All efforts will be made to gain the confidence and cooperation of our patients by warmth, humor, explanation and friendly persuasion. High quality dental care for children is our goal. Our office will make a great effort to ensure that your child feels comfortable in these new surroundings.

A parent is welcome to accompany their child on their first visit to view our office and to meet Dr. Pike and the staff. For the safety and privacy of all patients, other children and family members who are not being treated must remain in the reception area with a supervising adult. If you choose to accompany your child on their first visit, we ask that you please remain silent as a supportive observer. It is very important for Dr. Pike and the staff to establish a trust with the parent and child at the first visit in order to make an easy transition when the child returns for unaccompanied subsequent visits. This will allow the child to establish an uninterrupted relationship with Dr. Pike and staff and enables the patient to gain confidence during dental treatment. If at any time during the treatment we feel the need for parental involvement, we will invite the parent back.
I have read and understand the Office Policies and agree to abide by its contents:

Signature of Parent/Guardian:_____

Date:_____

1865 NW Boca Raton Blvd. Suite 102 Boca Raton, FL 33432
Phone: 561-347-7006 Fax: 561-347-7008 Online: www.pikepediatricdentistry.com

Pike Pediatric
DENTISTRY

Consent for Dental Treatment

I request and authorize Dr. Pike and her staff to examine and provide my child with comprehensive dental treatment including, but not limited to cleanings, fillings, crowns, extractions, and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Pike to diagnose and/or treat my child's dental condition. I understand that I will be responsible for any charges incurred on this child for dental treatment. 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. Pike 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.

Signature of Parent/Guardian:_____

Date:_____

Non-Guardian Consent

I give my permission for the following person(s) to accompany my child to his/her dental visits. All person(s) listed below must be over the age of 18. This includes making decisions regarding treatment that may arise during the scheduled appointment. This also gives Dr. Pike and her staff permission to discuss treatment and conditions with the person(s) listed below. I understand that I am responsible for payment at the time of services and should someone accompany my child other than myself, arrangements for payment must be made **before the scheduled appointment time.**

Name	Relationship to child
_____	_____
_____	_____

Signature of Parent/Guardian:_____

Date:_____

Pike Pediatric DENTISTRY

Financial Policy

Please understand that financial arrangements are made directly with you. For your convenience, the following outlines our financial policies:

1. **Payment is due in full** for each appointment as services are rendered and is to be paid by the person accompanying the child. We accept cash, personal checks (with valid photo ID), Mastercard, Visa, American Express, Discover and Care Credit. A charge of $30.00 will be assessed on checks returned for any reason. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.

2. **Dental Insurance:** Please check with our staff to make sure that we accept your child's insurance plan. For all insurances that we do not accept, we will be happy to submit a claim to your insurance electronically, however payment is due in full at time of service. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Any reimbursements by your 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 Authorization:** 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, Dr. Pike may recommend placing a silver crown instead of a resin filling.

5. **Nitrous Oxide / Analgesia:** Our office uses Nitrous Oxide Analgesia (Laughing Gas) for the comfort of our young patients. This fee is 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.

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.** *Understand 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 keep your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency.* ***I have read and understand my obligation.***

Signature of Parent/Guardian:_____

Date:_____

1865 NW Boca Raton Blvd. Suite 102 Boca Raton, FL 33432
Phone: 561-347-7006 Fax: 561-347-7008 Online: www.pikepediatricdentistry.com

Notice of Privacy Practices-HIPAA

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 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 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 for 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.

Signature of Parent/Guardian:_____

Date:_____

Pike Pediatric DENTISTRY

Patient Information

Patient Name_____ Nickname_____
Birthdate_____ Age____ Sex_____
Address_____ Apt/Suite#_____
City_____ State_____ Zip_____ Home #_____
School/Grade_____
Interests (favorite toy, hobbies, etc)_____
Names of siblings_____
Mother's Name_____ Birthdate_____
SSN #_____ Employer_____
Work #_____ Cell #_____ Email Address_____
Father's Name_____ Birthdate_____
SSN #_____ Employer_____
Work #_____ Cell #_____ Email Address_____
How did you hear about our office?_____
What is the reason for your child's visit today?_____
Any additional comments _____

Dental Insurance Information

Primary Policy Holder Name _____ SS# _____ Birthdate _____

Insurance Name & Address

_____
_____
_____

Employer's Name & Address

_____
_____
_____

ID # _____
Group # _____

I authorize my insurance to pay directly to Dr. Pike if my insurance plan is taken by Dr. Pike. If I am covered by any other plan, I will pay in full when services are rendered. I understand that all insurance policies are different and I am responsible for knowing my plan provisions. I understand I will be responsible for all co-payments, deductibles and any charges that are denied by my insurance plan.

Signature of Parent/Guardian:_____

Date:_____

Pike Pediatric DENTISTRY

Health History

yes no Is your child in good health?
Child's doctor_____ Date of last physical exam_____

yes no Has your child ever had a health problem?
If yes, please explain _____

yes no Are your child's immunizations up to date?

yes no Has your child had any operations?
If yes, please explain _____

yes no Did your child have any problems at birth?
If yes, please explain _____

yes no Is your child currently taking any medications?
If yes, please list _____

yes no Does your child have any known allergies?
If yes, please list _____

Please circle if your child has ever been diagnosed with or treated for any of the following:

ADD/ADHD	Cancer/Tumors	Heart Condition/Murmur	Psychiatric Care
AIDS/HIV	Cerebral Palsy	Hepatitis	Rheumatic Fever
Anemia	Cleft Lip/Palate	Kidney Disease	Sinus Problems
Asthma	Diabetes	Liver Disease	Social Delays
Autism	Epilepsy/Seizures/Convulsions	Mental Delays	Speech/Hearing Problems
Birth Defects	Excessive Bleeding	Measles	Stomach/GI Disease
Bladder Problems	Fainting	Mumps	Tuberculosis
Blood Disorder/Transfusion	Frequent Headaches	Physical Delays	OTHER

Please describe anything circled above _____
_____

Was your child breast fed or bottle fed?_____
At what age was it stopped?____

Did your child use a pacifier?_____ finger/thumb sucker?_____
At what age was it stopped?_____

Any other habits?_____

Pike Pediatric DENTISTRY

Dental History

yes no Has your child ever been to the dentist?
Name of previous dentist_____ Date of last visit_____

yes no Has your child ever had dental x-rays?

yes no Do you think your child will react well to dental treatment?
If not, please explain_____

yes no Does your child brush his/her own teeth?
How many times a day?_____

yes no Do you or your child floss his/her teeth?
How many times a week?_____

yes no Does your child use fluoride toothpaste?

yes no Do you give your child any fluoride supplements?
If so, please explain_____

yes no Does your child snack in between meals?_____

yes no Have your child's teeth ever been injured?
When?_____

yes no Does your child's jaw make noises?
If so, any pain associated with it?_____

Please circle if your child has any of the following:

Cavities	Gum Infection	Sensitive Teeth	Braces	Discolored Teeth
Jaw Sounds	Toothache	Grinding	Loose Teeth	

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my dentist if my child ever has a change in health.

Signature of Parent/Guardian:_____

Date:_____

Medical History Update
To Be Filled Out At Future Annual Visits

I have reviewed the attached health history.
The following has changed (if no changes, please write “no changes”):

_____

_____

_____

_____

Signature of Parent/Guardian:_____

Date:_____

Dental History Update
To Be Filled Out At Future Annual Visits

I have reviewed the attached dental history.
The following has changed (if no changes, please write “no changes”):

_____

_____

_____

_____

Signature of Parent/Guardian:_____

Date:_____

1865 NW Boca Raton Blvd. Suite 102 Boca Raton, FL 33432
Phone: 561-347-7006 Fax: 561-347-7008 Online: www.pikepediatricdentistry.com