Chelsea E. Garcia, DMD

Welcome to Our Practice!

Office Policies

We appreciate your 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

Parents are welcome to accompany their child into the treatment area during the initial examination and all appointments except for conscious sedation. This gives you the opportunity to see our staff in action and allows Dr. Chelsea to discuss dental findings and treatment needs directly with you. We do ask that if you accompany your child you assume the role of a silent observer. Your presence is greatly enhanced if you play a passive role. If more than one person is speaking to the child he/she may become confused. Cooperation and trust must be established directly between Dr. Chelsea and your child. We also ask that siblings remain in the reception room or play area. There may be times when the child's experience is enhanced by a parent's absence. We encourage older children to come back to the treatment area by themselves as this builds autonomy and trust. Older children, such as 6 years and older, typically do better without a parent present during a restorative (filling) appointment. Also, older children who are apprehensive may look for an "escape" by going to their parents. In this case, we may ask that a parent wait in the reception room during treatment in order to facilitate a more direct line of communication between the child and Dr. Chelsea.

Appointment Policy

If your child is under the age of 6 we ask that you schedule a morning appointment. Younger children do better when they are well rested. Missed appointment fee: The second time a patient does not show up on time for an appointment, or cancels with less than 24 hours notice, a $35 fee will be charged. This fee must be paid before a new appointment is scheduled. After three broken appointments within one year's time we will be happy to assist you in transferring the patient's records to another doctor.

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: _____

3725 12th Ct Suite B • VERO BEACH, FLORIDA 32960
PHONE: 772-562-6880 • Fax 772-562-6895
WWW.SEASIDESMILES.COM

3725 12 Ct. Suite B
Vero Beach, FL 32960
www.SeasideSmiles.com
Tel: 772-562-6880 Fax: 772-562-6895

PATIENT INFORMATION

Patient _____ Date _____
Nickname _____Birthday _____ Age _____ Sex _____ Wt _____lbs
Home Address _____ City _____Zip _____
Home Phone _____ Cellular Phone _____ Email _____
School _____ Grade _____
Names and ages of other children in family _____
Mother _____ Mother's Employer _____
Social Security #_____ Work Phone _____
Father _____ Father's Employer _____
Social Security #_____ Work Phone _____
Who has legal custody of patient? _____
Person responsible for payment of account _____ Date of Birth _____
Whom may we thank for referring you to us? _____
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 _____
Date of last physical exam _____

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

☐ Yes ☐ No Has your child ever 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
☐ Cancer / Tumors	☐ Heart Condition / Murmur	☐ Stomach / GI disease	☐ Frequent Infections	☐ Other

Please elaborate on any items checked _____
_____

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? Ages when? _____

☐ 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 snack 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
☐ Grinding (Bruxism)	☐ Gum infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____

_____

_____

FLUORIDE HISTORY

☐ Yes ☐ No Do you have city water? County Water?

☐ 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. Chelsea and her staff to examine, clean and provide my child with comprehensive dental treatment including 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. Chelsea 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. Chelsea 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. 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. 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 as services are rendered. We accept cash, personal checks, Mastercard, Visa, Discover and American Express. All checks will be verified using our TeleCheck system and a bank fee will be assessed on checks returned for any reason.
2. **Dental Insurance:** We are dedicated to providing all our patients with the *finest treatment available* and base our treatment recommendations on what will be best for your child and not what your insurance company does or does not pay. Please read the following in regards to your dental insurance coverage:
   (1.) We must emphasize that as a health care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a covered treatment. This percentage is determined by how much your employer has paid for coverage.
   (2.) As a courtesy, we will be happy to file your insurance benefits. *Any amount determined not to be covered by your insurance company is payable at the time services are rendered*; these fees may include deductibles, co-payments, certain procedures not covered by your insurance policy (ie: nitrous or sedation), and the difference between our fees and the amount covered by your insurance company.
   (3.) In the event your insurance carrier will not reimburse our office you will be responsible for the full cost of visits at the time services are rendered and your insurance company will send you the reimbursement check directly.
   (4.) We allow a maximum of 45 days for your insurance company to clear account balances. Any unpaid portions will be due in full, by you, after this period.
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. Chelsea 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.
7. **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered.
8. **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. An interest fee of 1.5% will be charged for all debts 60 days past due. If we have to refer your account to a collections agency, you agree to pay all our incurred collection costs. If we have to refer collection of the balance to a lawyer, you agree to pay all our incurred lawyer's fees plus all court costs. In case of a suit, you agree the venue shall be in Vero Beach, Florida.

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 keep fees as low as possible. I have read and understand my obligation.

Signature: _____ Date: _____

DENTAL INSURANCE INFORMATION

Insurance Carrier: Name: _____

I authorize my insurance company to pay directly to my dentist. 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-payments, deductibles, and rejected charges.

Signature: _____Date: _____

CONSENT FOR INTERNET COMMUNICATION

Our practice uses electronic medical records in an effort to reduce paper and promote efficiency. When possible, we store, send and receive records electronically including but not limited to, patient information and digital x-rays.

I grant my permission to the dental practice to send and receive confidential patient information (including account information, appointment information and clinical information) electronically to/from other practices. I hereby acknowledge that my confidentiality is **NOT** assured in my communication with Seaside Smiles Pediatric Dentistry, PLLC via email/internet. I do not hold Seaside Smiles Pediatric Dentistry, PLLC responsible for any breach of confidentiality that arises from using email/internet communication.

Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES - HIPPA

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 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 or treatment recommendations (such as voicemails, postcards, emails or letters).

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 complain to the US Department of Health and Human Services. If you have any further questions about our privacy practices please contact Dr. Chelsea.

Your signature below confirms that you have received a copy and read the Notice of Privacy Practices notice from our office.

Signature: _____ Date: _____