

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) Child's Information

Child's Name: _____			Nickname: _____		
Last	First	MI			
			Male <input type="checkbox"/> Female <input type="checkbox"/>		
Child's Birthdate ___/___/___			Child's Age: _____		
Child's Home#: (____) _____					
Child's Home Address:					

City		State		Zip	

2) Mother's Information: Step Mother Guardian

Name: _____		Birthdate: ___/___/___	
Cell#: (____) _____			
Occupation: _____		SS #: _____	
Email: _____			

Father's Information: Step_____her Guardian

Name: _____		Birthdate: ___/___/___	
Cell#: (____) _____			
Occupation: _____		SS #: _____	
Email: _____			

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

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 _____

Any concerns _____

Medical History

Name of Child's Physician _____ Phone _____ Last Visit _____

Medications _____

List all Allergies to (medications, foods, metals/alloys/other substance) _____

Does your child have/had any history of the following:

Please check all that applies

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart/Heart Murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Immunization | <input type="checkbox"/> Sex. Trans. Disease |
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Kidney | <input type="checkbox"/> Sickle cell or trait |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver | <input type="checkbox"/> Thyroid |
| Learning Issues | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Measles/Mumps | <input type="checkbox"/> Tobacco//Drug use |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy (teens) | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Previous Surgeries | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bones/Artificial Joints | <input type="checkbox"/> Hearing | <input type="checkbox"/> Previous Hospitalization | |

For the checked condition, how long? _____

List hospitalization/Surgeries/ER: _____

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 _____

Does your child need antibiotic prophylaxis prior to dental treatment for SBE Congenital Heart Issues OR other reasons? 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 _____

DENTAL INSURANCE POLICY

Charm Pediatric Dentistry accepts dental insurance as a courtesy to our patients. Please be informed that your insurance may not cover all procedures at 100%. Most insurances have deductibles, copays, and/or non-covered procedures. **We will do our best to let you know ahead of time what your copays/deductibles will be for a particular visit. However, it is the responsibility of the parent/guardian to know their coverages.**

OFFICE POLICIES

Payments: All payments such as non-covered services, deductibles and/or copays are due at time of service. If you have dental insurance, we will submit your claim to your dental insurance. However, your coinsurance is expected at time of service. We accept cash, check & major credit cards.

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.

No Show Policy: We have a strict “no-show” policy.

You must call us at least **24 hours in advance** if you cannot make your appointment. Anyone missing 3 appointments without giving a 24-hour minimum cancellation notice will be dismissed from the practice. **All “no-shows” are subject to a charge of \$20.00 fee** that is not covered by your insurance company.

Continuing Care Visits: Exams, cleaning and fluoride treatment are done every 6 months. Please be advised that some insurance covers fluoride only once a year. **Please contact your insurance regarding your coverage.** If you do not want fluoride treatment, please tell the office staff.

X-rays: X-rays are taken yearly or as needed, unless you tell us otherwise.

Referrals: Required referrals must be brought in before or on 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.

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. However, when these fails, there are several behavior management techniques 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. This 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 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.

By signing this form, I acknowledge that I understand the terms of the policies and agree to adhere to these policies.

Signature of Parent/Guardian

Date

HIPAA PRIVACY FORM

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)

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 or 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 these 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