

## Panhandle Pediatric Dentistry

### PATIENT INFORMATION

Patient \_\_\_\_\_ Date \_\_\_\_\_

Name child would like to be called \_\_\_\_\_ Birthday \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cellular Phone \_\_\_\_\_ Email \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Names and ages of other children in family \_\_\_\_\_ Primary Language \_\_\_\_\_

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 \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

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 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? \_\_\_\_\_

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

<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Mental delays
<input type="checkbox"/> Anemia	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Congenital birth defects	<input type="checkbox"/> Physical delays
<input type="checkbox"/> Asthma	<input type="checkbox"/> Excessive Bleeding	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Social delays
<input type="checkbox"/> Blood Disorder Transfusion	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Cleft lip / palate	<input type="checkbox"/> Speech / hearing problems
<input type="checkbox"/> Cancer / Tumors	<input type="checkbox"/> Heart Condition / Murmur	<input type="checkbox"/> Stomach / GI disease	<input type="checkbox"/> Frequent infections	<input type="checkbox"/> 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

- ☐ 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 have snacks 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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cavities                 | <input type="checkbox"/> Toothache      | <input type="checkbox"/> Sensitive teeth |
| <input type="checkbox"/> Surgical Mouth Treatment | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Color of teeth  |
| <input type="checkbox"/> Orthodontics             | <input type="checkbox"/> Jaw Sounds     | <input type="checkbox"/> Other           |

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## FLUORIDE

- ☐ Yes ☐ No Is your home water supply fluoridated?
- ☐ Yes ☐ No Does your child use 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 the dentist and his 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 the dentist 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. The dentist 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, MasterCard, Visa, American Express, Discover, and Care Credit as payment options.
2. **Medicaid Status:** It is the responsibility of the parent/guardian to confirm and maintain the insurance coverage as active for your child for each dental visit. If not listed as active, charges for the visit may apply or the appointment may be rescheduled.
3. **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 you, the insured patient, and your 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 you and/or your employer have 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, and the difference between our fees and the amount covered by your insurance company.
  - (3.) We will only file your *primary* insurance.
  - (4.) 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.
  - (5.) 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.
4. **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 pretreatment 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.
5. **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 copayment is your responsibility. In some cases, we may recommend placing a silver crown instead of a resin filling.
6. **Nitrous Oxide (Laughing Gas):** Nitrous Oxide is not always covered by dental insurance. We thank you for your payment on the date of service.
7. **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.
8. **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered.
9. **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 must refer your account to a collection 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. *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 in 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:**

**Primary Policy Holder:**

Name: \_\_\_\_\_

SS#: \_\_\_\_\_

**Insurance Carrier:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Group/Policy #:** \_\_\_\_\_

**Employer of Insured:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

**Patient ID#:** \_\_\_\_\_

I authorize my insurance to pay directly to my dentist. Our office will try to assist you with filing to most major **PPO** insurance companies as well as Medicaid Insurances. It is at Panhandle Pediatric Dentistry's discretion as to which policies we will assist in filing. I authorize my insurance company to pay directly to my dentist as an assignment of benefit for treatment rendered. If I am covered by any other plan, I will pay in full when services are rendered. 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:** \_\_\_\_\_

## 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 sedation appointments. This gives you the opportunity to see our staff in action and allows our doctors to discuss dental findings and treatment needs directly with you. We do ask 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 our staff and your child. We also ask that siblings remain in the reception room or play area if they do not have an appointment. 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 dentist.

### Appointment Policy

Your appointments are a reservation of space, equipment, the doctor's time, and the time of a number of auxiliary personnel. If you are unable to keep an appointment, 24-hour notice is customary and appreciated. **If you are more than 10 minutes late for your scheduled appointment you will be asked to reschedule your appointment or wait for the next available appointment time and will be noted as having a broken appointment.** Multiple broken appointments will result in dismissal from the practice.

1. All appointments must be confirmed either through our text reminder system or via phone call. If you do not confirm your appointment at least 5 days in advance, we will remove your appointment from our schedule. Confirmed appointments that are not kept and appointments that are cancelled within 24 hours of the appointed time will be charged a "broken appointment" fee of \$25 at the doctor's discretion. **Initial**
2. Radiographs (X-Rays): X-rays are recommended in our practice according to the guidelines set forth by the American Academy of Pediatric Dentistry. X-rays are necessary for a proper and thorough examination of your child's dental health and from time to time are required more frequently than your insurance will cover. In this case, you will be responsible for payment of the images. **Initial**
3. Fluoride: In-office fluoride is recommended at a minimum of every 6 months to assist in maintaining your child's dental health. Some insurance companies only cover fluoride treatment once a year. If your insurance chooses not to cover fluoride treatments as often as recommended you will be billed for the treatment. **Initial**
4. If your child is under the age of 6 or requires extensive restorative care, we ask that you schedule a morning appointment. Younger children do better when they are well rested. Dental appointments are an excused absence from school and you will be given an excuse slip prior to leaving the office. **Initial**

### Unattended Children

Our staff is not responsible for any children that are left in the waiting area or bathrooms unattended. Please provide proper, responsible adult supervision at all times of any children you bring into our office for their safety and the respect of others.

### Oral Hygiene

Good oral hygiene is one of the top priorities of our office. With good oral hygiene, your child may avoid uncomfortable and lengthy procedures due to dental decay. In addition, studies show all fillings, crowns, and orthodontic appliances will have a higher success rate and fewer complications if good oral hygiene techniques are followed. Our staff will educate and stress oral hygiene with the children and parents of this practice. If consistent poor oral hygiene is documented with your child, you may be dismissed from the practice or referred to another office.

### Contagious Illnesses

For the protection of the other patients and the staff, we ask that if your child has a rash, persistent vomiting, fever, lice or any other contagious illness, that you reschedule your child's appointment when your child is feeling better.

### 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:** \_\_\_\_\_

# Panhandle Pediatric Dentistry

**Child's Name** \_\_\_\_\_

**Date of Birth** \_\_\_\_\_

**Permission form for adults other than the parents or legal guardians to bring the child to the office for medical care, and to give consent for medical treatment.**

The purpose of this form is to allow you, the parent, the option of naming other adults to bring your child to Panhandle Pediatric Dentistry for dental evaluations and treatment. You will be giving permission for these adults to discuss your child's personal medical history with the staff and doctors as needed and to make medical decisions for you regarding the dental care of your child.

**If there are no adults listed, then your child will only be seen when brought by the parent or Legal Guardian.**

Date	Parent's Signed Initial	Name of Adult	Relationship to Child	Date & sign here <u>ONLY</u> when Removing Permission

This form may be modified in writing at any time at the request of either parent.

To remove an adult from this list, simply draw a line through the adult's name, sign your own name and date the time that you make the change in the column to the right.

**Print name of parent or Guardian** \_\_\_\_\_

**Relationship to child** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

## 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.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on 01/07/2013 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Jim Spring. Information on contacting us can be found at the end of this Notice.

### TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

**Treatment:** We may use your protected health information (PHI) including electronic protected health information (ePHI) to provide you with our professional services which may include electronic disclosure. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

**Disclosure:** We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

**(a) Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your health information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. Lists, if requested, will be \$1 for each page and the staff time charged will be \$10 per hour including the time required to locate and copy your health information. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**(b) Right to Request Restriction of PHI:** You may request a restriction on our use and disclosure of PHI, but we are not required to agree to your request. The HITECH Act restricts provider's refusal of an individual's request not to disclose PHI in instances where the disclosure is to a health plan for purposes of carrying out payment or health operations (and is not for purposes of carrying out treatment); and the PHI pertains solely to a healthcare item or service for which our facility has been paid out of pocket in full.

**Payment:** We may use and disclose your PHI and ePHI to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

**Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

**Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

**Required by Law:** We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

**Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

**Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.

**National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

### **YOUR PRIVACY RIGHTS AS OUR PATIENT**

**Access:** Upon written request, you have the right to inspect and get electronic copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our Privacy Officer for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$1 for each page and the staff time charged will be \$10 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for a fee and/or for an explanation of our fee structure.

**Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

**Non-routine Disclosures:** You have the right to request and receive an accounting of certain non-routine disclosures of your identifiable health information. We are required to maintain a log of these non-routine disclosures for a period of no less than six years beginning April 14, 2003. You can request non-routine disclosures going back 6 years starting on April 14, 2003.

**Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement (Except in emergencies). Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

**Breach Notification Requirements:** Beginning September 23, 2009, in the event unsecured protected information about you is "breached" and the use of the information poses a significant risk of financial, reputable or other harm to you, we will notify you of the situation and any steps you should take to protect yourself against harm due to the breach. We will inform HHS and take any other steps required by law.

---

### **QUESTIONS AND COMPLAINTS**

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision, we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and 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.

### **HOW TO CONTACT US**

Practice Name: Panhandle Pediatric Dentistry      Privacy Officer: Lorany Vazquez

Telephone: 850-481-1969    Fax: 850-481-1972

Address: 3123 West 23<sup>rd</sup> Street, Panama City, FL 32405

Email: berrydoc@ppdpc.net



## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

*Please print your name here*

*Signature*

*Date*

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation, it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

*Employee signature*

*Date*

## Panhandle Pediatric Dentistry

### May I accompany my child?

Parents are encouraged to come into the treatment area on the first visit to see the office and to meet our staff. We make great efforts to ensure that children feel comfortable in our office, after all that's what we're here for. We offer a safe environment where kids can learn about oral care in the presence of other children and our staff. We hope that you will become comfortable enough with our office to allow the kids to enter the treatment area by themselves on subsequent visits. Studies, and years of clinical experience have shown pediatric dentists that kids generally do better on their own than with a parent present. However, we feel you should have the choice to decide what is best for you and your child.

If a parent does choose to accompany their child into the treatment area, **we request that the parent act as a silent observer.** We will need to establish cooperation and trust directly with the child. If more than one person is communicating with the child at the same time, they tend to get confused and frustrated.

A child's first visit often sets the tone for subsequent attitudes about dental care and oral health. It is quite important to establish good feelings about going to the dentist. Our goal is not simply for your child to have a tolerable visit to our office, but to have a great visit where they will enjoy coming to the office and look forward to the next visit.

We have found that children react very well in our office when treated with kindness, patience, and humor. Kids will sometimes cry when faced with unfamiliar situations. If we work together, we can overcome any fears that they may have.

We have a highly personalized office that cannot accommodate all parents and siblings in the treatment area on every visit. Therefore, **we request only one parent accompany a child in the treatment area.** Occasionally, we will invite a younger sibling back to observe "Big Brother" or "Big Sister" prior to their first visit.

There may be times that we feel a child may respond better if unaccompanied, therefore, there may be times that we request a parent not accompany their child into the treatment area. If you are asked to remain in the waiting area please understand we are trying to best serve your child's needs. However, it may be helpful to some parents to have a "Visual". This allows a parent in the waiting room to come back in the middle of an appointment to surreptitiously view their child for a moment while treatment is in progress.

Please feel free to talk with the doctor after each and every visit if so desired. Your questions are welcomed!

**Please Initial** \_\_\_\_\_