PEDIATRIC DENTISTRY INFORMED CONSENT FOR PATIENT MANAGEMNT TECHNIQUES AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it. It is our intent to provide the best possible quality of professional care for each dental patient seen in our office.

Every effort will be made to obtain the cooperation of dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. Should the child dental patient exhibit signs of anxiety, we will resort to the most frequently used pediatric dentistry behavior management techniques, to obtain their confidence and cooperation. These techniques include:

Tell-Show-Do: The dentist, assistant, or hygienist explains to the child what is to be done using simple terminology and repetition and then show the child what is to be done by demonstrating with instruments on the child's finger or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive Reinforcement: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a sticker and a prize.

In most cases, the above methods result in a positive dental visit and effective treatment. In some instances, providing a high quality of care can be made very difficult, or in extreme cases, impossible, because of the lack of cooperation of a child patient. Among the behaviors that can interfere with our ability to provide needed dental care are: hyperactivity, resistive movement, refusing to open the mouth or keep open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or sharp dental instruments. In such cases, additional behavior management techniques may be required to eliminate disruptive behavior and/or prevent patients from causing injury to themselves due to uncontrollable movements. The most commonly used pediatric dentistry behavior management techniques for these situations are listed below.

Voice Control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of command.

Mouth Props: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refused, or has difficulty maintaining an open mouth.

Physical Restraint by the Dentist: The dentist restrains the child from movement by holding down the child's hands or upper body gently, stabilizing the child's head between the dentist's arm and body, or positioning the child firmly in the dental chair.

Physical Restraint by the Dental Assistant: Then dental assistant restrains the child from movement by holding the child's hand, and/or controlling leg movements.

Physical Restraint by the use of a Papoose Board: The papoose board is also known as a "hug blanket". It is a board in which the child is laid on, and then wrapped with a Velcro blanket. This is used only if all of the above methods aren't working. This blanket, not only protects the child from injury during the dental procedure, but allows the dentist to provide the necessary treatment for your child in a safe way. The child is not held in the blanket for any longer than deemed necessary to get the procedures done.

By signing below, I acknowledge that I have been informed of Dr. Lin's management techniques.

_____ _____

Signature of parent or legal guardian Date of signature

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Office Policies

In order for us to run our office more efficiently and better serve our patients, we have adopted the following policies.

1. **You are responsible for supplying our office with all current insurance information required to file your claims for payment. Due to the time involved with calling individual insurance companies, our staff will no longer call to obtain this information.**
2. **All co- pays or deductibles are due at the time of services.**
3. **There is a $15 fee for all returned checks.**

If you arrive without the proper insurance information, you will be expected to pay for the services at the time of your appointment. To prevent this situation please contact our office with all insurance information prior to your appointment.

4. **Children cannot be dropped off or left unattended in the office. Parents must be present until the appointment is complete.**
5. **If you arrive more than 15 minutes late for your appointment, we reserve the right to reschedule for another day.**
6. **We require 24 hours notice when canceling an appointment, otherwise you may be billed for the visit.**
7. **We need a current telephone number on file so we can attempt to confirm your appointment. If we do not have a current phone number and are unable to reach you, to confirm your appointment we may elect to cancel it.**
8. **If you have more than one appointment scheduled, and you fail to show, we will automatically cancel any future appointments.**
9. **If you miss more than one of your appointments without notifying us, we will refer you out of the office.**

These policies are made so that we may better serve out patients; we thank you in advance for your cooperation.

Respectfully,

Douglas Lin, D.D.S., M.S. And staff

Due to the number of patients waiting for an appointment, we will not reschedule your appointment if you fail to show.

Notice of Privacy Practices Acknowledgement

Practice name
Address
City, State ZIP

DOUGLAS LIN, D.D.S., INC.
DENTISTRY FOR CHILDREN
5130 E. MAIN ST.
COLUMBUS, OHIO 43213
(614) 868-0718

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its' *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

PATIENT RECORDS

Today's Date_____

Child's Full Name_____DOB____/___/___M or F

Street Address_____City_____Zip_____

Mother's Name_____SS#_____D.O.B___/___/___

Street
Address_____City_____Zip_____

Phone: Home (_____)_____Work (_____)_____

Employer_____

Father's Name_____SS#_____D.O.B___/___/___

Street
Address_____City_____Zip_____

Phone: Home (_____)_____Work (_____)_____

Employer_____

Dental Insurance

Name of Primary Insurance_____

Address and Phone Number _____

Name of Secondary Insurance_____

Address and Phone Number_____

How did you hear about our office or name of person that referred you_____

Has you child ever been seen by a dentist? Yes No If so, when?_____

Address of previous dentist_____Phone #_____

Any serious or difficult problems with previous dental work?_____

Were any x-rays taken? Yes No Any particular problem today?_____

Name and phone number of child's physician_____

*****OVER*****

CHILD'S MEDICAL HISTORY

Y	N	HEART MURMUR	Y	N	MITRAL VALVE PROLAPSE
Y	N	CANCER	Y	N	RHEUMATIC FEVER
Y	N	DOWNS SYNDROME	Y	N	HIV OR AIDS
Y	N	AUTISTIC	Y	N	HEMOPHILIA
Y	N	DEVELOPMENTAL HANDICAPS	Y	N	CONVULSIONS/EPILEPSY
Y	N	CONGENITAL HEART DEFECTS	Y	N	HEPATITIS
Y	N	DIABETES	Y	N	KIDNEY/LIVER PROBLEMS
Y	N	ASTHMA	Y	N	ABNORMAL BLEEDING
Y	N	TUBERCULOSIS (TB)	Y	N	ALCOHOL/DRUG PROBLEM
Y	N	STAYS IN HOSPITAL	Y	N	ALLERGIES TO DRUGS
Y	N	OPERATIONS			

Please explain any "Y" here and list any other medical condition not listed above.

_____

_____

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. I will be held in the strictest 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, including x-rays.

_____

Signature of parent/guardian Date

I certify that my child is covered by the insurance I stated on the front of this form and I assign directly, to this office, all insurance benefits, otherwise payable to me. I understate that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____

Signature of parent/guardian Date

I authorize the use of nitrous oxide (laughing gas) for dental treatment

_____

Signature of parent/ guardian Date