



Michael Roseff, DMD

## Welcome to Our Practice!

### Office Policies

We'd like to thank you for 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

We invite you to stay with your child during examinations and procedures as an observer NOT participant, unless otherwise directed by staff or Dr. Roseff. Our goal is to gain your child's confidence, trust, and overcome any apprehension.

*We strive to make each and every visit to our office a fun one!*

#### Disclosure

Our office believes in utilizing an open friendly environment to make your child feel welcome. In doing so, we may display your child's name in our office or picture. We may also utilize electronic resources, such as our Facebook Fan Page "Roseff Pediatric Dentistry" or the informational TV in the waiting room.

#### Appointment Policies

AGE: If your child is under the age of 6, we ask that you schedule a morning appointment. In our experience, we have found that younger children tend to do better when they are well rested.

**NO-SHOW: Missed appointments without 24-hour notification are considered "NO SHOW" appointments and will result in a \$50.00 fee. This fee must be paid prior to being scheduled again.**

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

**Roseff Pediatric Dentistry**  
8784 Boynton Beach Blvd, #103  
Boynton Beach, FL 33472  
Phone: 561.732.8333 Fax: 561.732.8375

**PATIENT INFORMATION**

Child's Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Nickname: \_\_\_\_\_ Birth Date: \_\_\_\_\_ Gender: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Email: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cellular): \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_  
Names of siblings: \_\_\_\_\_  
Mother's Name: \_\_\_\_\_ Mother's Employer: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Father: \_\_\_\_\_ Father's Employer: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Who has legal custody of patient? \_\_\_\_\_  
Whom may we thank for referring you to our practice: \_\_\_\_\_  
What is the reason for your child's dental visit? \_\_\_\_\_  
Emergency Contact other than parents: \_\_\_\_\_  
Relationship to child: \_\_\_\_\_ Phone: \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Primary Policy Holder: Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Insurance Carrier Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Group/Policy Number: \_\_\_\_\_  
Employer of Insured: \_\_\_\_\_  
Patient ID Number: \_\_\_\_\_  
  
Secondary Policy Holder: Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
Insurance Carrier Name: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Group/Policy Number: \_\_\_\_\_  
Employer of Insured: \_\_\_\_\_  
Patient ID Number: \_\_\_\_\_

I authorize my insurance to pay directly to my dentist if my insurance plan is Aetna PPO, Cigna PPO, Delta Dental PPO, Delta Dental Premier, Dentemax, Guardian PPO, Humana, MetLife PDP, Safeguard PPO & HMO, GEHA, United Concordia, Principal, Florida Blue Options (PPO & Copay), and DeCare. If I am covered by any other plan, I will pay in full prior to being seen. 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: \_\_\_\_\_

## HEALTH/MEDICAL HISTORY

Yes  No Is your child in good health? Name of child's physician: \_\_\_\_\_

Physician's Phone Number: \_\_\_\_\_

Date of last physical exam: \_\_\_\_\_

Yes  No Is your child presently under the care of a physician? Please Explain: \_\_\_\_\_

Yes  No Has your child ever had a health problem? Please Explain: \_\_\_\_\_

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? \_\_\_\_\_

Yes  No Was your child Breast Fed? If so, what age stopped? \_\_\_\_\_

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

- |  |  |   |  |  |
|--|--|---|--|--|
| <input type="checkbox"/> ADD/ADHD                      | <input type="checkbox"/> Cancer/Tumor                            | <input type="checkbox"/> Eye Conditions                         | <input type="checkbox"/> Hepatitis/Liver Disease             | <input type="checkbox"/> Sickle Cell Disease                 |
| <input type="checkbox"/> AIDS/HIV                      | <input type="checkbox"/> Chemical Dependency                     | <input type="checkbox"/> Females: Are you pregnant?             | <input type="checkbox"/> High Blood Pressure                 | <input type="checkbox"/> Social Delays                       |
| <input type="checkbox"/> Anemia                        | <input type="checkbox"/> Chicken Pox                             | <input type="checkbox"/> Females: Are you taking Birth Control? | <input type="checkbox"/> Injury to Front Teeth               | <input type="checkbox"/> Speech Impairment                   |
| <input type="checkbox"/> Asthma                        | <input type="checkbox"/> Cleft Palate/Lip                        | <input type="checkbox"/> Frequent Headaches                     | <input type="checkbox"/> Kidney Disease                      | <input type="checkbox"/> Stomach/GI Disease                  |
| <input type="checkbox"/> Autism                        | <input type="checkbox"/> Cold Sores/ Canker Sores                | <input type="checkbox"/> Frequent Infections                    | <input type="checkbox"/> Mental Delays                       | <input type="checkbox"/> Thyroid Disease                     |
| <input type="checkbox"/> Behavioral Problems           | <input type="checkbox"/> Congenital Birth Defects                | <input type="checkbox"/> Frequent Urination                     | <input type="checkbox"/> Metallic Implant, Shunts, Pins/Rods | <input type="checkbox"/> Tonsillitis                         |
| <input type="checkbox"/> Bleeding Gums                 | <input type="checkbox"/> Developmental Delayed (Age level: ____) | <input type="checkbox"/> Hearing Impairment                     | <input type="checkbox"/> Physical Delays                     | <input type="checkbox"/> Transplants, Organ (specify: _____) |
| <input type="checkbox"/> Blood Disorder or Transfusion | <input type="checkbox"/> Diabetes                                | <input type="checkbox"/> Heart Disease                          | <input type="checkbox"/> Premature Birth (weeks: _____)      | <input type="checkbox"/> Tuberculosis                        |
| <input type="checkbox"/> Bone/Joint Problems           | <input type="checkbox"/> Earaches/Ear Infections                 | <input type="checkbox"/> Hearing Impairment                     | <input type="checkbox"/> Prolonged Bleeding When Cut         | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Brain Injury                  | <input type="checkbox"/> Epilepsy/Seizure Disorder               | <input type="checkbox"/> Heart Murmur                           | <input type="checkbox"/> Psychiatric Care                    | <input type="checkbox"/> Other: _____                        |
| <input type="checkbox"/> Cerebral Palsy                | <input type="checkbox"/> Excessive Bleeding                      | <input type="checkbox"/> Hemophilic                             | <input type="checkbox"/> Rheumatic Fever                     | <input type="checkbox"/> Other: _____                        |

Is there any other health information that should be known?  Yes  No Please Explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 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? Please Explain: \_\_\_\_\_  
\_\_\_\_\_
- Yes  No Has your child had recent dental pain? Please Explain: \_\_\_\_\_  
\_\_\_\_\_
- Yes  No Does your child have a specific dental problem that needs attention? Please Explain: \_\_\_\_\_  
\_\_\_\_\_
- Yes  No Does your child suck a finger, thumb or pacifier? Age when stopped: \_\_\_\_\_
- Yes  No Does your child drink from a Bottle or Sippy Cup? Age when stopped: \_\_\_\_\_
- 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 any member of the family have excessive decay or fillings?
- 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"/> Teeth grinding/clinching |

Comments:

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## FLUORIDE HISTORY

Does your child PRIMARILY receive (check all that applies):

- Tap Water    Well water    Bottled Water    Fluoridated Bottled 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. Roseff and his staff to examine, clean and provide my child with comprehensive dental treatment including fluoride, fillings, crowns, extractions and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary for Dr. Roseff 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. Roseff 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.

I have given an accurate report of this patient's physical, mental, dental, and fluoride health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Michael J. Roseff and the staff of Roseff Pediatric Dentistry of any changes in the medical history. This authorization is valid until revoked by me in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## RADIOGRAPH(S) POLICY

Radiographs are the only way to reliably view the bone, roots, attachments, interproximal areas, and under and around restorations. Radiographs provide a starting point for what conditions exist today, and what changes may occur by the patient's next appointment. Detection of harmful conditions such as cancer lesions and abscesses are often impossible without radiographs.

Our office uses the ALARA principal when taking radiographs, this means we use As Low As Reasonably Achievable levels of radiation, using digital radiology, protective gowns and collars, and devices to reduce scatter and concentrate the beam into the smallest area possible.

Radiographs will of course be on an individual basis based on the needs of the patient, proximity of the teeth, caries risk, age, and level of cooperation. Detecting caries early is the best way to ensure the best treatment techniques are used including preventive strategies. Once you are able to see the cavity, often it is too late to treat with minimally invasive therapy.

There will be no exceptions, if Dr. Roseff recommends radiographs, and you wish not to have them taken, we will not treat your child and prefer you see another dentist.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL POLICY

**Please be aware that the parent bringing the child to our office is responsible for payment of all charges at the time of appointment.** 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. In order to insure the most accurate financial information, and for the security of our patients, we require a valid social security number or driver's license. For the convenience of our patients, the following alternatives are listed as a guide for possible financial arrangements:

1. **Payment is due in full at the time of appointment. Payment is required prior to patient being seen.** (We will notify parent/guardian of ESTIMATED charges prior to appointment time, and if any, refunds will be given on work not completed prior to departing office. We accept Cash, MasterCard, Visa, and Discover. A charge of \$30.00 for declined credit card transactions assigned for payment plans. If multiple credit cards are used for a single payment, Roseff Pediatric Dentistry will charge a \$5.00 service fee. Roseff Pediatric Dentistry will **not be accepting personal checks.**
2. **Dental Insurance:** It is our policy to not accept assignment of benefits for dental insurance other than Preferred Provider Organization (PPO), such as: Aetna, Cigna, Delta Dental PPO/Premier, Guardian, Metlife/Safeguard, etc. Please call office for additional insurance companies. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Any reimbursements by you insurance company other than those we directly participate with should be made directly to you according to the terms of your contract with them.

FINANCIAL POLICY continued

3. **Pre-treatment Authorizations:** 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, the dentist may recommend placing a silver colored 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 at time and 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. If the appliance breaks, there may be an additional fee for the associated lab costs.
7. **Emergency Treatment:** All emergency treatment must be paid in full at the time of service. 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 to keep your fees as low as possible. I have read and understand my obligation.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES - HIPAA

### 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 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 and/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, 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.

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_