Dr. Julie M. Russo
Diplomate of the
American Board of Pediatric Dentistry

Office Policies

We appreciate your allowing us to provide dental care for your child. We value our relationship with you and believe that the best relationships are based on understanding and good communication; we offer these clarifications of our office policies.

What to expect during your first visit at Clermont Pediatric Dentistry

Your child's initial visit is the first step towards them becoming a confident and comfortable dental patient for life. Research has shown that children over the age of 3 react more positively when permitted to experience the dental visit on their own and in an environment designed for children. This helps to better establish a rapport with your child to encourage their trust and independence.

We know that this appointment is also your first visit with us, so we want you to be comfortable and confident in the treatment your child is receiving from us. In order to build that same trust with you, we are glad to offer you the opportunity to observe your child in the treatment area. This observation opportunity is given after any necessary x-rays are completed and your child is settled in the dental chair. We respectfully ask that you be a "silent observer" at this time. After the observation opportunity we will review x-rays with you, discuss any concerns not noted on the paperwork you completed, and relay that information to Dr. Russo.

Upon completion of your child's appointment, we will discuss any necessary treatment and the costs associated with these treatments. At this point you will have the opportunity to meet Dr. Russo and address any further questions regarding the treatment.

We also understand that each child is different and may need a modified approach to their appointment. We will be glad to work with both you and your child to provide them with the best possible appointment and treatment.

Appointment Policy

If your child is under the age of 6 we request that you schedule a morning appointment. Younger children do better when they are well rested. Your scheduled appointment time has been reserved specifically for your child. We request 24 business hours notice if you need to cancel an appointment. We are aware that unforeseen events sometimes require missing an appointment. However, if you do miss an appointment without notifying us 24 business hours in advance, a cancellation fee will be applied to your account. The cancellation fee will vary depending on the length of time reserved for you and your child.

Infection Control

We utilize the most effective infection control measures and fully comply with all OSHA and CDC standards for sterilization. We maximize our use of disposable materials and autoclave all of our hand instruments.

We welcome any questions!

I have read and understand the Office Policies and agree to abide by its contents:

Parent/Guardian_____ Date:_____

3165 Citrus Tower Boulevard, Clermont Florida 34711
Phone: 352-241-6333 • Fax: 352-241-0706
www.ClermontPediatricDentistry.com

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PATIENT INFORMATION

Patient _____

Name child would like to be called _____ Birthdate _____ Age _____ Sex _____

Address _____ Apt/Suite# _____

City _____ State _____ Zip _____ Home Phone _____

School / Grade _____

Child's Interests (favorite toy, movie, etc) _____

Names and ages of other children in family _____

Mother _____ Employer _____

SS# _____ Birthdate _____ Work Phone _____

Email Address _____ Cell Phone _____

Father _____ Employer _____

SS# _____ Birthdate _____ Work Phone _____

Email Address _____ Cell Phone _____

Who has legal custody of the patient? _____

How did you hear about our office? _____

What is the reason for your child's dental visit? _____

Additional Comments _____

_____

_____

_____

_____

DENTAL INSURANCE INFORMATION

Primary Policy Holder Name _____

SS# _____ DOB _____

Insurance Carrier Name _____

Address _____

_____

Group/Policy # _____

Subscriber ID# _____

Employer of Insured Name _____

Address _____

_____

_____

I authorize my insurance company to pay Clermont Pediatric Dentistry directly. I understand that all insurance 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 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 list medication(s), dose(s), and reason(s) _____

_____

☐ Yes ☐ No Were there any problems at birth? _____

☐ Yes ☐ No Is your child allergic to anything? _____

Please check if your child has been diagnosed, treated or is being 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 problems
☐ Cancer / Tumors	☐ Heart Condition / Murmur	☐ Stomach / GI disease	☐ Frequent infections	☐ Autism
☐ ADD/ADHD	☐ Psychiatric Care	☐ 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? If not, explain: _____

☐ Yes ☐ No Has your child ever sucked a finger, thumb or pacifier? Ages when? _____

☐ Yes ☐ No Does your child brush his/her own 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 teeth? _____

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
☐ Surgical Mouth Treatment	☐ Gum Infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____

_____

_____

FLUORIDE HISTORY

☐ Yes ☐ No Is your home water supply fluoridated?

☐ 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? _____

FINANCIAL POLICY

Please understand that financial arrangements are made directly with you. For your convenience, the following outlines our financial policies:

1. **Payment is due in full** for each appointment as services are rendered and is to be paid by the person accompanying the child. We accept cash, personal checks (with valid photo ID), Mastercard, Visa, American Express, Discover and Care Credit. A charge of $30.00 will be assessed on checks returned for any reason. You will be responsible for payment of all costs and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.

2. **Dental Insurance:** It is our policy to not accept assignment of benefits for dental insurance other than those we are contracted with. If you are unsure if we are a provider for your insurance company please ask a staff member. For all other insurances we will be happy to submit a claim to your insurance electronically, however payment is due in full at time of service. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits. Any reimbursements by your insurance company other than those we directly participate with should be made directly to you according to the terms of your contract with them.

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 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.

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 co-payment is your responsibility. In some cases, the dentist may recommend placing a silver crown instead of a resin filling.

6. **Nitrous Oxide / Analgesia:** Our office uses Nitrous Oxide Analgesia (Laughing Gas) for the comfort of our young patients. This fee is 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.

Please remember, even if you have insurance coverage, **you are responsible for payment of your account.** *Understand 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 your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency. You agree to pay any and all attorney fees associated with the collection of monies due.* ***I have read and understand my obligation.***

Signature: _____ Date:_____

CONSENT FOR DENTAL TREATMENT

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for treatment of my child or for the purpose of payment of the account or credit references. Furthermore, since your child is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any dental service can be started and accomplished by Dr. Julie and/or legally qualified associates or partners.

Such authorization is hereby granted to administer any treatment, anesthetics, and perform such operations or otherwise manage my child as may be deemed necessary or advisable. I understand I will be consulted before any treatment is rendered.

I do, however, give specific consent to do an examination, take appropriate x-rays, clean the teeth, give a fluoride treatment, and provide oral hygiene instructions if deemed necessary. I also authorize the use of photographs, radiographs, other diagnostic materials, and treatment records for the purpose of teaching, research, and scientific publications. I also give permission to provide emergency care, if needed.

I further understand this consent will remain in effect until such time as I choose to terminate it.

If you have any objections to the above, please so state.

Print: _____ Date:_____
Parent or Legal Guardian *Relationship to Child*

Signature: _____ Date:_____
Parent or Legal Guardian

_____ Date:_____
Witness

PERMISSION CONSENT

I give my permission for the following person(s) to accompany my child to his/her dental visits. All person(s) listed below must be over the age of 18. This includes making decisions regarding treatment that may arise during the scheduled appointment. This also gives Dr. Russo and her staff permission to discuss treatment and conditions with the person(s) listed below. I understand that I am responsible for payment at the time of services and should someone accompany my child other than myself, arrangements for payment must be made ***before the scheduled appointment time***.

Name	Relationship to child
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____ Date:_____