Lancaster County Pediatric Dentistry
Specialized care for children
Michael Lemper DMD
Pediatric Dentist
325 Carol Lynn Dr.
Willow Street, PA 17584
(717)464-0230
willowstpediatricdentist.com

Patient Registration Form

Child's Name:_____ DOB:_____

Nick Name:_____ Gender: Male Female

Home Adress:_____

Home Phone:_____ Cell Phone:_____

Parent/Foster Parent/Legal Guardian information (Mother/Guardian)

Name:_____ Relationship:_____

DOB:_____ Social Security #:_____ Email address:_____

Employer:_____ Occupation:_____

Parent/Foster Parent/Legal Guardian information (Father/Guardian)

Name:_____ Relationship:_____

DOB:_____ Social Security #:_____ Email address:_____

Employer:_____ Occupation:_____

Primary Dental Insurance

Insured's Name:_____ Relationship to patient:_____

Date of Birth:_____ Social Security #_____

Subscriber ID:_____ Employer:_____Group#_____

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Financial/Insurance Agreement

I hereby authorize the office of **LCPD** to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents. I hereby authorize payment of dental benefits otherwise payable to me directly to the office listed above. I have reviewed the treatment plan and fees. I agree to be responsible of all charges for dental services and materials not paid by my dental benefits plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to the claim**.** This dental office is authorized to fill out and/or to assist me to complete any and all insurance forms pertaining to services rendered. This Dental Office is also authorized to sign my name to insurance forms when payment is due if I am not to present to sign at the time of completion of the form.

Parent/Guardian initials:_____

FINANCIAL POLICY

I understand that I am financially responsible for all services rendered by the **LCPD** unless prior arrangements have been made. These services must be paid in full at the time of treatment. If I have dental insurance, I must make proper co-payments at the time of treatment, and I am totally responsible for anything the insurance company does not pay; furthermore, if the insurance company does not pay because your coverage was lapsed on the date of service, you are responsible for the full fee billed to insurance. This authorization will be valid from this date and shall expire in two years. A photocopy of this document may act as an original. If payment for service is not paid after 60 days your account may be sent to a collection agency and additional fees assessed to cover collection agency fees.

Parent/Guardian initials:_____

FINANCIAL ARRANGEMENTS

For your convenience we offer the following methods of payment. Please check the option(s) your prefer. Payment in full is due at each appointment: ____ Cash _____ Personal Check ____Visa ____ Master Card

I authorize **LCPD** to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/ or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependents behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

_____
Signature of parent or Legal Guardian & Date
Financially Responsible person for account __ Self __ other

Staff Initials_____

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Medical & Dental History Form

Childs Name:_____ Date of Birth_____ Male____ Female___

Primary Care Physician:_____ Phone No:_____

Purpose of Dental Visit:_____ Last Dental Visit:_____

Has your child ever had any of the following?	Yes	No	Comments/ Please Explain...
Heart Murmur			
Congenital heart disease			
Liver Disease/Hepatitis/Jaundice			
Kidney disease			
Skin, Bone, Muscle or joint disease			
Seizures/Convulsions/ Loss of Consciousness			
Cerebral Palsy, or Neurological Disease			
Sexually Transmitted Disease or HIV			
Anemia, Hemophilia, Other blood disorders			
Sickle Cell disease or trait			
Cancer			
Tumors or Growths			
Asthma or respiratory			
Speech Disorder or Hearing disorder			
Mental, Emotional, or developmental Delays			
Autism, ADHD, Genetic Disorder/Syndrome, anxiety or depression (please Note)			
Has Your child ever received blood/blood products or suffer from High or low blood pressure?			
Has your child ever been hospitalized for a serious illness or surgery?			
Is your child taking any medications? (please specify)			
Is your child allergic to any medications ?			
Persistent Cough Greater than three weeks ?			

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Has your child had any of the following?	Yes	No	Comments
Pain in the teeth			
Swelling of the mouth and face			
Injury to the face			
A bad dental experience			
Does your water have fluoride			
Does your child thumb suck or other oral habit			
Does your child have any other dental condition			
Has your child ever been seen by a dentist? (If Yes please provide the date)			Date:
Has your child ever had dental radiographs taken? (Please explain)			

Any other medical information that was not listed above please list here:_____

_____

_____

Any concerns about your child's teeth you would like the dentist to talk to you about?

_____

_____

_____

Patients Name:_____ Parents Name_____

Parent Signature & Date:_____

Doctors Signature:_____

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Appointment Agreement

Broken Appointments

Definition: a scheduled appointment is considered a broken appointment when the patient:
CANCELS THE APPOINTMENT WITH LESS THAN 24 HOURS NOTICE, OR
FAILS TO KEEP APPOINTMENT WITH NO NOTICE
During the case of a broken appointment there is a $50.00 fee for each appointment that is broken.
The time the dentist sets aside for a patient is very valuable. Broken appointments make it difficult for our office to maintain a schedule that is efficient for our staff and convenient for our patients. For this reason, patients may be charged for broken appointments. This charge is not a penalty but an attempt to maintain the fair compensation for the time needed or care and the cost of that time. The doctor has limited amounts of appointment time, and this time should not be wasted. Please help us provide a quality dental care at affordable prices by coming on time for your appointments. Of course, we will not charge the fee in the event that an emergency lead to a broken appointment according to either of the above definitions.

I UNDERSTAND THERE IS A $50.00 FEE FOR ALL BROKEN APPOINTMENTS, EXCEPT IN THE EVENT OF EMERGENCIES.

Parent/Legal Guardian's Initials:_____

Late Arrivals

When we reserve time for your child, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplis this. If you arrive more than 10 minutes late for your hygiene appointment or 15 minutes late for your operative appointment your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit. If this happens it will be considered a missed appointment

Parent/Legal Guardian's Initials:_____

Any unpaid outstanding balances must be paid in full before we can schedule your childs next appointment with our office. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services.

Patients Name:_____ Parent/legal guardian's Name:_____

Parent/Legal guardian's signature & Date:_____

Staff Initials:_____

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Hippa Compliance/Consent for Treatment/Nitrous Oxide

Hippa Compliance

I am aware that this office is HIPPA compliant, and all of my medical and dental information will be held in the strictest confidence, will only be seen by the dentist, his staff to the extent that such is necessary for treatment, and only disclosed to insurance companies for the purpose of billing or obtaining preauthorizations, or to other medical/dental professionals if the dentist deems a consultation with them is necessary for safe and effective treatment; or to other medical/dental professionals for the purpose of referral.

Consent for Treatment

I hereby authorize Michael Lemper DMD a dentist duly authorized in the State of PA to perform dentistry and administer nitrous oxide/oxygen analgesia, to examine, diagnose, and treat my child in such a manner as he sees fit in accordance with currently accepted dental practice. I understand that Dr. Lemper will discuss my child's treatment with me and obtain verbal consent before any specific procedures; he will also discuss treatment options and the risks and benefits of pursuing each option. I understand that there are risks to pediatric dental treatment, including but not limited to: a child crying or otherwise becoming upset during treatment; and a child biting their lip while anesthetized, or "numb".

Nitrous Oxide

Nitrous Oxide is a colorless, slightly sweet gas that is used during dental treatment for relaxation and anxiety relief. When inhaled it can induce feelings, or euphoria and sedation. It can also produce sensation of drowsiness, warmth, and tingling in the hands, feet, and/or about the mouth in the dental setting it will not induce unconsciousness. Your child will be able to swallow, talk, and cough as needed.

Patient Name:_____ Parent Name:_____

Parent signature & Date:_____

Staff Initals:_____

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Permission Form

This form gives the authorized person(s) permission to make dental and medical decisions for your child. This includes any changes to the treatment plan at the time of services and changes in the financial estimate if any.

I, _____ give my permission to
(Guardian's Name)

_____
(authorized Person(s))

to bring my child(ren) _____

to his/her dental appointments at Lancaster County Pediatric Dentistry. I give my consent that the person(s) named above may make dental and medical decsions for my child(ren) until further Notice.

Guardian's Signature_____ Date_____