Appointment Policy

Welcome to Irmo Smiles Pediatric Dentistry! We are glad you have made an appointment for your child for important oral health care. Regular dental visits every 6 months including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointments! Valuable time has been reserved for your child's care. A missed appointment results in lost time which could be used for another patient waiting for treatment. Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. The office attempts to schedule appointments at your convenience and when time is available. Preschool children (5 years old and younger) should be seen in the morning because they are fresher and we can work more slowly with them for their comfort. Children having restorative treatment (fillings, extractions, etc.) have a much better experience in the morning for the same reason.

We are looking forward to seeing you and your child at their next visit. Please take a moment to familiarize yourself with our appointment policy. Thank you!

Broken/Missed Appointments

Your child's scheduled appointment is reserved specifically for them. We try to remind patients by telephone prior to the appointment, but please do not depend on this courtesy. If a cancellation is unavoidable, please call the office at least 24 hours in advance so that we may give your child's appointment time to another patient. If you do not cancel your child's appointment with 24 hours' notice or if you do not bring your child to the appointment, we will consider this to be a broken/missed appointment. If 2 broken appointments occur, our office reserves the right not to schedule any subsequent appointments for your child.

Occasionally, children's illnesses or other unexpected emergencies make it necessary to cancel an appointment with less than 24 hours of notice. Please contact our office immediately and we will do our best to accommodate your situation.

Late Arrivals

If you arrive more than 10-15 minutes late for your child's appointment, you may be asked to reschedule for the next available appointment time. Again, please call at least 24 hours in advance if a cancellation is unavoidable.

Appointment Delays

We strive to see all patients on time for the scheduled appointment. We make every effort to stay on schedule. Additionally, there are times when our schedule is delayed to accommodate an injured child or emergency. Please accept our apology in advance should this occur during your child's appointment. We will provide you the same courtesy if your child is in need of emergency treatment. We ask that if your child is not called back in a timely fashion, please notify a staff member.

Please plan to arrive 10 minutes before your scheduled appointment. This allows time for parking and time to complete any additional paperwork. A parent or legal guardian (with official documentation) must be present in the office during the initial examination or any restorative appointments.

For the safety and privacy of all patients, other children who are not being treated should remain in the reception area with a supervising adult.

I have read and understand Irmo Smiles Pediatric Dentistry's appointment policy.

Parent/Guardian Signature	Child's Name (or Children)	Date

Pediatric Dentistry
Child Dental History

About Your Child

Child's Name _____ Nickname _____ DOB _____ Sex ◯ M ◯ F

Address _____ Contact Phone _____

Father's Name _____ Cell Phone _____ Work Phone _____

Mother's Name _____ Cell Phone _____ Work Phone _____

Responsible Party Name _____ DOB _____ SSN _____

Billing Address (if different from above) _____

Email Address (to receive appt. reminders/correspondence) _____

How did you hear about our office?

◯ Self ◯ Dentist ◯ Insurance Company ◯ Online Search ◯ Others _____

Insurance Information

Subscriber's Name _____ DOB _____ SSN _____

Subscriber's Address (if different from above) _____

Subscriber's Phone (Cell) _____ Alternate Phone _____

Subscriber's Employer _____ Occupation _____

Name of Insurance Company _____

Insurance Company Phone _____ Group # _____ ID# _____

Dental History

Date of last dental visit _____ Name of previous Dentist _____

Reason for visit _____ Date of last dental x-rays _____

May we request prior records if necessary? ◯ Yes ◯ No

Has your child complained about dental problems? ◯ Yes ◯ No If yes, please explain. _____

_____

Has your child experienced any unpleasant dental experiences? ◯ Yes ◯ No If yes, please explain.

_____

Are there any oral habits we should know about? (thumb/pacifier/etc.) ◯ Yes ◯ No If yes, please explain.

_____

Does your child brush teeth daily? ◯ Yes ◯ No

Do lyou assist your child with teeth brushing? ◯ Yes ◯ No ◯ Sometimes

Does your child take any fluoride supplementation? ◯ Yes ◯ No ◯ Sometimes

Is dental floss used? ◯ Yes ◯ No ◯ Sometimes

Has your child worn any orthodontic appliances, now or ever? ◯ Yes ◯ No If yes, please explain.

_____

Has your child suffered any injuries to mouth/teeth/head? ◯ Yes ◯ No If yes, please explain.

_____

How would you describe your child's overall attitude towards dentistry?

_____

Pediatric Dentistry
Child Health History

Health History

Child's Primary Care Physician _____

Physician phone _____ Office location _____

Is your child currently under the care of a physician/doctor/dentist? ◯ Yes ◯ No

If yes, please explain._____

Is your child currently under the care of a psychiatrist/psychologist? ◯ Yes ◯ No

If yes, please explain._____

Is your child currently taking any medications or drugs (vitamins, prescriptions, etc.?) ◯ Yes ◯ No

If yes, please explain._____

Does your child experience any excessive bleeding when cut? ◯ Yes ◯ No

If yes, please explain._____

Has your child ever been hospitalized or had surgery? ◯ Yes ◯ No

If yes, please explain._____

Does your child have any allergies to drugs, antibiotics, latex, dyes, etc.? ◯ Yes ◯ No

If yes, please explain._____

May we request the release of your child's medical records for our reference? ◯ Yes ◯ No

Has the child ever had any history or difficulty with any of the following? (Please check all that apply.)

◯ AIDS/HIV	◯ Cerebral Palsy	◯ Fainting	◯ Mastoid
◯ Anemia	◯ Chronic sinus	◯ Hearing Problems	◯ Mononucleosis
◯ Asthma	◯ Convulsions	◯ Heart	◯ Pregnancy (teen)
◯ Autism	◯ Diabetes	◯ Hepatitis	◯ Rheumatic Fever
◯ Blood/bleeding disorders	◯ Ear aches/infections	◯ Kidney	◯ Tobacco use
◯ Bone/joint replacement	◯ Epilepsy/seizures	◯ Liver	◯ Thyroid
◯ Cancer			

◯ Other _____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should know. _____

_____

Consent for Services

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for the patient referenced on this form. I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

Parent/Guardian Signature _____ Date _____

Irmo Smiles Financial Policy

Thank you for choosing Irmo Smiles for your dental needs. Our staff is committed to providing you with the best care possible. Your clear understanding of our financial policy is critical to our professional relationship. In order to eliminate the possibility of financial misunderstandings we require a signature to document that you have read and understand this policy.

Irmo Smiles prepares a treatment plan estimate so that patients can understand the estimated costs of their recommended treatment prior to its start. The treatment plan estimate is a good-faith attempt to predict the cost of treatment based on the facts known to Irmo Smiles when the estimate is made. As treatment progresses your dentist may determine that different or additional treatment is necessary and cost of treatment may change.

INSURANCE: Our staff will provide an estimate of insurance benefits for planned treatment in an attempt to calculate the patient's financial responsibility. However, insurance plans vary considerably and we cannot guarantee what portion of services will or will not be covered. It is the responsibility of the patient/guarantor to provide accurate and timely insurance information to our staff. Inaccurate or untimely information given to the staff that results in denial or non-coverage by the insurance company results in the guarantor being financially responsible for payment. Examples of inaccurate or untimely information include but are not limited to coverage which has changed or terminated and procedures which have been performed at other offices but have not been fully processed by the insurance company. Dental insurance is a contract between the patient and their insurance company, as such it is the patient's responsibility to understand and verify eligibility before procedures are performed. Any balance not paid by the insurance company becomes the patient's financial responsibility.

NOTE: Irmo Smiles is NOT an in-network provider with any insurance plan for dental services. We are in-network with some insurance plans for orthodontic services ONLY.

PAYMENT/BILLING: Full payment is due at the time services are rendered. Any patient who does not pay their balance at the time of service will be placed in a pre-payment status for a period of 18 months. During this period said patient will be required to pre-pay their portion of any treatment before scheduling and will be ineligible for in-house payment arrangements. In the event that financial arrangements are needed all arrangements must be made at the time of scheduling the appointment. We realize that temporary financial problems may affect timely payment on an account. If such problems arise it is the patient's responsibility to contact our billing department promptly for payment arrangements and assistance in management of the account. Any balance remaining after 60 days is subject to referral to a collections agency and reporting to the 3 major credit bureaus. Patient/guarantor will be responsible for any costs incurred if account is turned over to a collection agency including collection agency fees, attorney fees and any associated court costs.

FEES: A $35.00 fee will be assessed for all returned checks. Interest will accrue on all balances unpaid within 30 days of the date of service at a rate of 1.5% per month.

I, _____ (print name) have read, understand and agree to the Irmo Smiles Financial Policy.

Patient/Guarantor's Signature _____ Date _____

Authorization for the Release of Dental Records

Today's Date _____

Patient Name _____

Date of Birth _____

I hereby authorize the doctor and staff of _____

to obtain/release records or knowledge concerning my dental health to/from:

Irmo Smiles
Attn: Pediatric Team
7321 St. Andrews Road
Irmo, SC 29063
(803) 749-4001

We specifically request copies of ALL CURRENT X-RAYS AND TREATMENT NOTES.

Signed (Parent/Guardian) _____

Printed Name _____

Please email these to _____

Thank you!

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PURPOSE OF CONSENT: BY SIGNING THIS FORM YOU WILL CONSENT TO OUR USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT ACTIVITIES, AND HEALTHCARE OPERATIONS.

Notice of Privacy Practices: You have the right to read our notice of privacy practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected healthcare information, and of other important matters about your protected health information.

A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our "Notice of Privacy Practices." If we change our privacy practices, we will issue a revised "Notice of Privacy Practices", which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed on this form. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____, have had full opportunity to read and consider the contents of the consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT ONCE SIGNED

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting our office at

Telephone (803)749-4001 • Fax (803)749-8966
Email: info@irmosmiles.com
Address: 7321 St. Andrews Road, Irmo, SC 29063

FOR OFFICE USE ONLY: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____