Dear Parents,

We are pleased that you have chosen our practice to care for your child's dental needs. We will do everything possible to earn your confidence. A child's first visit often sets the tone for subsequent attitudes about dental care and oral health. It is quite important to establish good feelings about going to the dentist. Our goal is not simply for your child to have a tolerable visit to the dentist, but to have a great visit where they will enjoy coming to the office. Your child will enter a "safe environment" where they will meet other children and learn about their dental health. We have found that children react very well in our office when treated with kindness, patience, and humor.

You can play a major role in preparing your child to see the dentist. The first visit includes a thorough cleaning, topical fluoride treatment, oral hygiene instruction, and any necessary diagnostic dental x-rays to ensure a comprehensive examination. Simply explain to young children that Dr. Lindsey will count their teeth, clean them with a special tickling toothbrush and take some pictures of their teeth. It is very important that this be done in a calm and easygoing manner. Any anxiety on your part will be sensed by your child.

We make a great effort to ensure that children feel comfortable in our office and parents are encouraged to come into the treatment area on the first visit to see the office and meet Dr. Robinson. For subsequent appointments we have an open door policy and you can choose to accompany your child in the treatment area. If we sense that a child may do better on his own, we will suggest a parent step out of the treatment area in order for us to establish cooperation and trust with the child.

Our team will do everything possible to allow your child to grow up with a healthy dentition and a positive attitude towards dentistry. We feel that good communication is the key to this goal. Please don't hesitate to ask questions or discuss any phase of treatment with us.

We look forward to seeing you and your child.

Sincerely,

Dr. Lindsey and Team

Lindsey Robinson, D.D.S.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
Federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We are required to follow the practices that are outlined in this Notice while it is in effect. This Notice takes effect September 23, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We disclose medical/dental information to our employees and others who are involved in providing the care you need. We may use or disclose your health information to another dentist or other healthcare providers providing treatment that we do not provide. We may also share your health information with a pharmacist in order to provide you with a prescription, or with a laboratory that performs tests or fabricates dental prostheses or orthodontic appliances.

Payment: We may use and disclose your health information to obtain payment for services we provide to you, unless you request that we restrict such disclosure to your health plan when you have paid out-of-pocket and in full for services rendered.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include, but are not limited to, quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. You have the right to request restrictions on disclosure to family members, other relatives, close personal friends, or any other person identified by you.

Unsecured Email: We will not send you unsecured emails pertaining to your health information without your prior authorization. If you do authorize communications via unsecured email, you have the right to revoke the authorization at any time.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We may contact you about products or services related to your treatment, case management or care coordination, or to propose other treatments or health-related benefits and services in which you may be interested. We may also encourage you to purchase a product or service when you visit our office. If you are currently an enrollee of a dental plan, we may receive payment for communications to you in relation to our provision, coordination, or management of your dental care, including our coordination or management of your health care with a third party, our consultation with other health care providers relating to your care, or if we refer you for health care. We will not otherwise use or disclose your health information for marketing purposes without your written authorization. We will disclose whether we receive payments for marketing activity you have authorized.

Change of Ownership: If this dental practice is sold or merged with another practice or organization, your health records will become the property of the new owner. However, you may request that copies of your health information be transferred to another dental practice.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Lindsey Robinson, D.D.S.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, ______________________________, have received a copy of this office's Notice of Privacy Practices

____
(please print name)

____
(signature)

____
(date)

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:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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This form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002)

Lindsey A. Robinson, DDS
Pediatric Dentistry

REGISTRATION

Child's Name__________ Nickname__________ Age______ Date of Birth__________

Child's Address__________ Home Phone__________ Gender M / F

City, Zip__________ School__________ Grade__________

Mother's Name__________ Marital Status__________ Date of Birth__________

Home Address__________ Home Phone__________

Cell Phone__________ SSN__________ Driver's License No__________

Employer__________ Occupation__________ Work Phone__________

Father's Name__________ Marital Status__________ Date of Birth__________

Home Address__________ Home Phone__________

Cell Phone__________ SSN__________ Driver's License No__________

Employer__________ Occupation__________ Work Phone__________

Guardian's Name__________ Date of Birth__________

Home Address__________ Home Phone__________

Cell Phone__________ SSN__________ Work Phone__________

Other children in your family (names & ages)__________

Household E-mail__________

Whom may we thank for referring you to our office?__________

Cell Phones: I consent to the dental practice using my cell phone number to call or text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time.

__________ __________
Parent / Guardian Signature Date

FINANCIAL ARRANGEMENTS

Person responsible for patient's account__________

If your child is covered by dental insurance, which parent is the primary dental insurance carrier?__________

Insurance Co__________ Group No__________ Co Phone No__________

Parent's Social Security No__________ Secondary Insurance Carrier__________

Payment for services is due at time services are rendered. We accept cash, checks, Mastercard, Visa, and Discover. We will be happy to process your insurance claim for you; however, we need to inform you that any fees incurred are your personal responsibility regardless of insurance. I hereby authorize payment of the dental insurance benefits otherwise payable to me directly to Lindsey A. Robinson, DDS.

__________ __________
Parent / Guardian Signature Date

Lindsey A. Robinson, DDS
Pediatric Dentistry

HEALTH HISTORY

Name of Child______________________________ Date____________________
Purpose of today's visit (any specific concerns)____

Medical History: In order to render the best possible care and treatment for your child, your assistance is needed in answering the following questions.

1. Does your child have a health problem?__________ If so, What?______________________________
2. Is your child under the care of a physician?________ Name & phone no____________________________
3. When was your child's last physical exam?________ Reason for last exam__________________________
4. Is your child current on his immunizations?____
5. Is your child taking any medications now?________ Medication name______________________________
6. Has your child ever been hospitalized?___________ When & why?_________________________________
7. Has your child ever experienced any unfavorable reaction or is allergic to any medicine…such as penicillin, aspirin, local anesthetic or latex?____
8. Has your child had unfavorable experiences with medical or dental care?____________________________
9. Does your child have or has your child ever had any of the following:

yes	no		yes	no		yes	no	
□	□	Heart Murmur	□	□	Epilepsy	□	□	Hyperactivity
□	□	Heart Disease	□	□	Cerebral palsy	□	□	Emotional Disturbance
□	□	Rheumatic Fever	□	□	Seizures	□	□	Developmental Delay
□	□	Asthma	□	□	Liver Disease	□	□	Mental Retardation
□	□	Allergies	□	□	Tuberculosis	□	□	Hearing Problems
□	□	Anemia	□	□	Kidney Disease	□	□	Speech Problems
□	□	Bleeding Disorders	□	□	Diabetes	□	□	Hepatitis A, B, etc.
□	□	Other______________						

Dental History:

10. Has your child been to a dentist before?_______ Who?____________________ Last Visit?________ X-rays Taken?_______
11. Does your child have any oral habits (Finger Sucking, Grinding Teeth, Pacifier, Thumb Sucking)?__________________
    If yes, please explain____
12. Is your child receiving daily fluoride at the present time?__________________ In what form?__________________
13. Does your child have a toothache now?______________________________ Has ever had one?______________
14. Is there anything we should know about your child before beginning a dental examination?____________________
____

_______________________________________ ____________________
SIGNATURE DATE

Lindsey A.
Robinson DDS
pediatric & endodontic dentistry

453 South Auburn Street
Grass Valley, CA 95945 (530) 272-5522

INFORMATION ABOUT OUR PRACTICE

Appointments:

We recognize how very valuable your time is; therefore, we schedule our dental appointments very carefully to assure all of our patients that they are seen promptly and that sufficient time is allotted for every procedure. Occasionally, a regularly scheduled patient may be required to wait in order for us to accommodate an emergency patient.

Cancellations and Broken Appointments:

If you find it is impossible to keep your appointment, please tell us ahead of time. In this way, we can reschedule your appointment and let another child have the time you could not make. For this reason we ask for a 48-hour's notice of cancellation. There will be a $30 charge for any appointments missed or cancelled at short notice.

Insurance Information:

We will be happy to process your insurance forms for you as long as you provide a current proof of coverage card with you. We must have that information at the time of the appointment in order to bill your insurance; otherwise, you will be responsible for any charges incurred for the visit. Please be familiar with your insurance coverage and understand:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Not all services are a covered benefit in all insurance company contracts. Some insurance companies arbitrarily select certain services they will not cover.
3. As healthcare providers, our relationship is with you, not your insurance company.
4. Any amount remaining once your insurance company has processed your claim; will be billed to you.

Financial Policy:

Payment is to be received the day that services are rendered. We accept cash, checks, Visa, MasterCard, and Discover. For those with insurance, your deductible and co-pay percentage are due at each visit. Payment plans are available for larger treatment plans which can be arranged through our business manger. Returned checks will be subject to a $20 charge. Balances over 30 days will be assessed a 1.5% interest charge per month.

If you have any questions about the above information, please do not hesitate to ask us. We are here to help you.

________________________________ ________________
Signature Date