Children's Dentistry Of Sanford, LLP

Mark S. Lucier, D.M.D.
Megan J. Lucier, D.M.D.
955 B Main St
Sanford, Maine 04073
Telephone: (207) 324-0026
Fax: (207) 324-0013

Thank you for your interest in our office. Please find enclosed our new patient paperwork that is needed by our office in order to schedule your child with a new patient appointment. Once we have received the materials from you we will review the information and call you to schedule an appointment time that is convenient for you. You can send the paperwork back via mail, fax, or drop it off.

Please note a couple items that will be required when you bring your child to their first appointment:

1) Legal guardian needs to be present at the initial appointment so that you can meet the Doctor and discuss treatment with them. If there is to be an exception to this rule it must be made in advance with the office manager and for very good cause. If you are not the biological parent of the child then we require copies of the paperwork that establishes that you are guardian.
2) Please bring any and all insurance cards. If we do not have all the necessary information it is possible that we will not be able to see your child. Completing and sending this paper work in advance should greatly reduce any confusion regarding insurance.
3) Please plan to arrive 5 minutes before the start of your child's appointment so that our office can establish them as patients in our computer system.

If you have any questions please do not hesitate to contact the office at the number listed above. Once received and reviewed we will be contacting you to schedule an appointment for your child(ren).

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Initial Visit

Your child's first visit to our office is a very important one. This allows us to build a relationship with the patient and gain their trust. When your child comes in for a comprehensive exam, they will first see one of our hygienists. At this time, our staff will provide a cleaning, x-rays, topical fluoride application, and an exam by the doctor. Feel free to accompany your child into the operatory during this first visit. This gives our staff the opportunity to discuss your child's dental needs with you, and proceed with a course of treatment should one be needed.

Why Does My Child Need X-rays?

Radiographs (x-rays) are an integral part of dentistry. There are parts of the tooth and the bone underneath that are not visible to the naked eye without use of an x-ray. Radiographs are important in the diagnoses of cavities, especially in between the teeth. Without the use of these, we may not know that a cavity between the teeth exists. Cavities in primary teeth grow very quickly; therefore our office updates x-rays on a yearly basis. If you are not comfortable with this policy, feel free to talk to ask our staff about any concerns.

Bitewing X-rays: Allow the dentist to see cavities in between the back teeth-taken once a year.
Panoramic X-ray: Allow the dentist to see all of the teeth in one film, even developing teeth. This x-ray is used for orthodontic reasons. It also allows us to see placement of wisdom teeth in the jaw-taken once every two years.
Periapical X-ray: Allows the dentist to see a specific area or tooth. These are important in the diagnoses of infection around the roots of teeth-taken as needed, usually in the instance of patient discomfort.

Why Does My Child Need Fluoride at Their Dental Appointment?

Even if your child receives fluoride at home, we still recommend the use of fluoride at the dental office. Our hygienists use a topical fluoride with a high concentration in order to give your child's teeth a boost. Also, other topical fluorides, such as toothpastes and rinses are dependant upon patient compliance and correct use of such products. In office, we are able to control the environment in which your child receives fluoride in order to ensure proper use. This way, we can be sure your child's teeth are getting the maximum uptake of fluoride in the given time.

Note: Children should be seen every six months or two times a year.

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Children's Dentistry Of Sanford, LLP

Mark S. Lucier, D.M.D. Pediatric Dentist
Megan J. Lucier, D.M.D.

Welcome to Children's Dentistry and thank you for choosing our office to help you with your child's health care needs. It is our hope that, together, we can teach you and your child the healthy habits necessary for a lifetime of oral health. We cannot do the job alone. It is critical that this partnership begins early between our staff, the child and the parent. These tools must be regularly reinforced, and when problems arise both the problem and the means from where it started be addressed. Ideally, we can deem this adventure a success when we are only seeing each other twice a year for regular cleanings, fluoride, and checkups. Emergencies may arise, and you can always count on us being no more than a phone call away to alleviate any problem.

So let's take a few lines and review some critical office policies and common questions so that you are ready for your child's first visit.

One of our most commonly asked questions is "Are parents allowed to accompany their child for treatment?". The answer to this question is quite simply, yes. However, it should be noted that **one** parent may accompany the child (there simply isn't room for Mom, Dad, and Uncle Bob). Also, the "crowd" often distracts from information gathering and addressing the problems that you have come to the office to rectify. Siblings are welcome in the office, but they too cannot accompany the child into treatment areas (unless they are an infant in a car seat). Our goal is to treat your child. Siblings are often distractions to the child and staff, and can cause harm to themselves and others in the operatory. If you want to be present for your child's treatment, please plan accordingly. Unfortunately, we do not make exceptions to this rule as it could compromise the safety of your child and other children being treated in the office. Should you choose to accompany your child, please understand that it is what we call a "silent partner". This partnership is based on the need to develop a relationship between the child and the dentist or hygienist. Our goal is to establish a parent and child's trust, like a school, that we will safeguard their care and psyche whether you are present or not. Parents also regularly use language and innuendo that can confuse a child and complicate treatment. We are specialists in fixing children's teeth and also in explaining complicated procedures in simple ways that they both understand and can accept.

Like baseball, we too have a three strikes rule. If you miss three appointments, and by miss we mean either not showing up or not providing 48 hours notice that you cannot make the appointment, then it is our assumption that you do not value the services that our office offers both during and after hours. We value patients that value our services. Three missed appointments indicates to us that we might not be a great

fit for each other and it becomes our right to dismiss your child and / or your family from our office. Our software tracks this information and generates reminders when an appointment is missed. We also confirm appointments with you, as a courtesy, with at 24-48 hours notice. Ultimately, it is the responsibility of our parents to make certain that the child comes to the appointment. We will help remind you, but it is ultimately the parents responsibility.

We also have a ten minute tardy policy. Quite simply, if you are ten minutes late to an appointment, we are going to reschedule the appointment for a future date and count it as a missed appointment. Arriving late ensures two things. First, that the work that we will complete is rushed and not to our standards. Second, it is likely to delay treatment on the child who is scheduled after your child (we believe that it is unfair to punish those who arrive to their appointments on time - we run on time nearly 98% of the time).

Finally, let's address what our role as providers is in regard to your child. When disease (cavities, infected teeth, etc) is found, our job is to inform you about it, gather information from you regarding how your child will react during treatment, and make suggestions that both ensure the work is completed and no trauma to your child's psyche occurs. Often, when many cavities are present, there is a feeling of neglect on the part of the parent. Please understand that your child having cavities is not a sign of neglect; failing to treat the disease once a parent is informed that it is present **is** neglect. We are obligated, by law, to report cases of neglect and suspected abuse. To date, we are unaware of a dentist that has ever caused a cavity. Our role is to be available to treat the diseases of the mouth and offer guidance to prevent future recurrences. Sometimes, treatment is simple and inexpensive. Treatment that is not completed in a timely manner runs the risk of pain, complication, and increased cost.

The greatest treatment we can provide to your child is not orthodontics, fillings, or whitening their teeth, it is prevention. In office fluoride treatment, and teaching proper brushing and flossing are the three greatest weapons we employ. We review the practices of prevention at every appointment; preventing a cavity is always an easier visit than treating a cavity.

We are excited to have you in our family and we look forward to meeting with you and your child.

Sincerely,

Mark S. Lucier, DMD
Pediatric Dentist

Megan, J. Lucier, DMD
General Dentist

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____ Birth Date: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ ADD/ADHD
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism/Aspergers
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due date: _____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

_____
Print name- Patient/Guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient (please specify below)

☐ Dental Office (please specify below) ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

The following is for: ☐ the person responsible for payment ☐ the legal guardian of the patient

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____

PLEASE PROVIDE AS MANY PHONE NUMBERS AS POSSIBLE AS WELL AS AN E-MAIL ADDRESS:

Home Phone #: _____ Work Phone #: _____ Ext: _____ Best time to call: _____

Cell Phone # (if applicable): _____ E-Mail Address***: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Additional Parties

I authorize disclosure of information to the parties listed below in addition to myself (Include additional parent if applicable)

Name: _____ Relation to Patient: _____

Address: _____

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Social Security #: _____ Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

*** E-Mail address is to be used for communication purposes in conjunction with our office website only (i.e. e-mailed confirmation of appointments, reminders, newsletter, etc.) and will not be distributed or sold under any circumstances. If you have questions or concerns please speak with one of our staff members.

We strive to provide your child with the best care possible. Please be advised of the following policies that will help us greatly in that endeavor:

In coming to this office you have read and understand the following:

1) We have a strict policy that we require 48 hour notice for any appointment that can not be kept. If an appointment is cancelled within 48 hours of the appointment it will be considered as broken, regardless of the reason.

2) We have a policy that after three missed appointments a family become subject to dismissal. Please note that this potentially applies to all children in the family. If one child misses three appointments it places the entire family in jeopardy.

3) We require that patients present for their appointments at their scheduled time. Ideally, each patient would arrive for their appointment 5 minutes early. If you are more than 5 minutes late we might be forced to reschedule your appointment depending on the nature of your appointment (i.e. planned treatment). Our office runs by the time we have in our office at the front desk.

4) We guarantee restorative work only so long as a patient is coming in for regular recalls at six month intervals. If a filling comes out and we have not seen your child in one year it is possible that you will be responsible for all, or a portion of, the customary charge.

5) Our records need to remain as complete as possible. This includes medical history, contact information, insurance information, etc. It is your responsibility to notify us of any changes in the items mentioned above.

6) We do not allow food or drink past the waiting room. This is for your safety.

7) Use of cell phones is strictly prohibited. We will delay treatment until such time as the distraction has ceased. It is at our discretion to remove you form the treatment area in the case of multiple infractions.

8) For the safety of everyone at this office we do not allow more than one person to accompany a child into the treatment area. This includes multiple parents and siblings. The only exception to this rule would be an infant restricted in a car seat.

9) I understand that there might be a fee to transfer records if my account is not in good standing.

_____ _____

Signed (Parent or Guardian) Date

Photograph Agreement

There are different times when we would want to take photographs of your child either for record recognition which would remain in the child's chart in our computer system only. Also, the 'No Cavities Club' in which the child's picture would be posted on the wall inside the office. Please sign acknowledging and allowing the pictures to be taken and possibly posted.

___ I would like my child's photograph to be taken and possibly posted inside the office of Children's Dentistry of Sanford

___I do NOT want my child photographed.

PRIVACY POLICY (HIPAA)

Children's Dentistry of Sanford, LLP takes patient privacy very seriously and protecting confidential health information is of the utmost concern to our office.

Please be advised of the following regarding our privacy practices:

We will use and disclose your health information as it pertains to three topics: treatment (i.e. working with other providers-orthodontists, oral surgeons, etc); payment (i.e. to obtain payment from an insurance company) or healthcare operations (various action taken by health care companies-i.e. audits; quality assessments, etc.). There are times when we will disclose your child's information to another healthcare provider without consent. You can request disclosure of health information to any party. It is our office policy that said request must be done in writing to our office. Release of this information will be done at our discretion. We can, at our discretion, impose a reasonable, cost-based fee for the cost of copying said records. Any permission that you provide to our office can be revoked at any time and must be done in writing. Our general office policy is that disclosure of information to anyone other than the legal guardian requires explicit written consent. At times implied consent may be applied and information shared with a caretaker that has brought the patient to the appointment (i.e. treatment needs; scheduling appointments, etc.). If an emergent situation arises and we are unable to obtain consent from a legal guardian we will use our best judgment in releasing any information to any caregivers. Information will be transmitted until such time as written consent can be obtained from the patient's legal guardian. Please be advised that we are required by law to make certain disclosures to the Department of Health and Human Services if they request information from our office. Please also be advised that we are required by law to disclose information when we suspect abuse or neglect. Our office often times will use mailings or phone calls as a way of contacting patients (i.e. appointment reminder cards, continuing care cards, birthday cards, correspondence regarding missed appointments, etc.). These can be restricted by you at any time. If you would like to restrict these we request a formal written request. Although our office makes every effort to protect information, from time to time an incidental disclosure of information may happen when another patient or parent may hear a conversation in our office. We make every effort to minimize and eliminate any possibility of this happening however at times it will be unavoidable. Our office will employ a principle of minimum necessary when releasing information and only release essential information.

Below is a brief summary of your rights as our patient:
It is our policy that our patients always have access to their designated record set. Depending on who is making the request we may request a written request fro release of information. Also, it is at our discretion to impose a reasonable and customary fee for release of records. We will make every effort to release records as expeditiously as possible, however preparation of same may, at times, take two full business days depending on the nature of the request received. Patients are allowed to amend their records when we have complete or inaccurate information. Individuals have a right to a disclosure accounting if requested from the patient. We must release only certain disclosures that have occurred in the past six years. Patients may file a restriction request whereby we would be restricted in our use or disclosure of protected health information. We are under no obligation to grant this request however if we do grant the request we must comply with the restrictions unless in the case of a medical emergency. Said requests for restrictions must be made in writing. Our office generally uses four methods of communication: verbal face to face communication; regular United States mail (letter or postcards); telephone communications; and electronic mail. You can restrict any of these at any time by submitting a written request. This can include something as simple as restricting telephone numbers that we use.

Below are your options if you do not agree with a disclosure or restriction we have made:
If you are worried about a disclosure or restriction we have made regarding your record please submit written correspondence regarding same to Privacy Coordinator; Children's Dentistry of Sanford, LLP; 955 Main Street, Sanford, ME 04073. You can also direct questions regarding this policy to the Drs. Lucier or the privacy coordinator who is the office manager. You can also, at any time, submit a written complaint to the Secretary of Health and Human Services. Please direct any questions regarding this policy to the Privacy Coordinator.
This privacy policy is effective as of the date signed below.

_____ _____

Patient/Guardian Signature **Date**

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I further agree to advise Children's Dentistry of any and all changes to my insurance plan. I understand that it is my responsibility to advise your office of changes in employment which result in a change in insurance carrier.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of parent or guardian/person responsible for payment

_____

Printed Name of parent or guardian/person responsible for payment