CDCY™
CHILDREN'S DENTAL
CENTRE OF YORK

Angela S. Lutz, D.M.D.
David F. Laughlin, D.D.S.
Diplomates of the American Board of Pediatric Dentistry
Robert W. Bowser, D.M.D.

Welcome

We are pleased to welcome you to our pediatric dental practice. We look forward to providing you with the most modern and thorough pediatric dental care available. Our staff can provide your child with care ranging from preventative to complete rehabilitation.

Appointments

For your convenience the office will be open for dental services during the following hours:

Monday	7:45 a.m. - 4:30 p.m.
Tuesday	7:45 a.m. - 4:30 p.m.
Wednesday	7:45 a.m. - 4:30 p.m.
Thursday	7:45 a.m. - 4:30 p.m.
Friday	Apple Hill Surgical Center (by appointment only)

If you cannot keep your scheduled appointment,
Please give us 24 hours notice

Emergency Care

We recognize that emergency situations do arise and we will do our best to respond promptly. We have a 24 hour answering service.

1399 South Queen Street, Suite A York, PA 17403 (717) 741-0848 www.childrensdentalcentre.com

CDCY™
CHILDREN'S DENTAL CENTRE OF YORK

Angela S. Lutz, D.M.D.
David F. Laughlin, D.D.S.
Diplomates of the American Board of Pediatric Dentistry
Robert W. Bowser, D.M.D.

Date: ____/____/____

Child's Name: _____ ❑ Male ❑ Female

Nickname: _____ Birthdate: ____/____/____ Age: _____

Child's Address: _____

Child's Home Phone #: ( ) _____ School: _____ Grade: _____

Siblings (Names/Ages): _____

Who is accompanying this child today? _____ _____
FULL NAME (if other than parent) Relation to Child

Do you have legal custody? ❑ Yes ❑ No Is this child adopted? ❑ Yes ❑ No Is this child in foster care? ❑ Yes ❑ No

Mother's Name: _____
❑ Stepmother ❑ Guardian

Date of Birth: ____/____/____

Home Address: _____

_____

Home #: ( ) _____

Cell #: ( ) _____

Employer: _____

Address: _____

_____

Work #: ( ) _____

Father's Name: _____
❑ Stepfather ❑ Guardian

Date of Birth: ____/____/____

Home Address: _____

_____

Home #: ( ) _____

Cell #: ( ) _____

Employer: _____

Address: _____

_____

Work #: ( ) _____

Primary Dental Insurance:

Insured's Name: _____

SS #: _____ ID# _____

Group #: _____ D.O.B. _____

Co. Name _____

Address: _____

Phone #: ( ) _____

Insured's Relation to Patient: _____

Insured's Employer: _____

Secondary Dental Insurance:

Insured's Name: _____

SS #: _____ ID# _____

Group #: _____ D.O.B. _____

Co. Name: _____

Address: _____

Phone #: ( ) _____

Insured's Relation to Patient: _____

Insured's Employer: _____

❑ *I hereby authorize assignment of my insurance rights directly to the provider for services rendered. I fully understand that I am solely responsible for any balance not paid by my insurance company.*

How Did You Learn of CDCY? ❑ Billboard ❑ Magazine ❑ Website (Search Engine) ❑ Autism York
❑ Facebook ❑ PreSchool Presentation ❑ Weeuseables Consignment Event ❑ Drove by Office ❑ Sibling is Patient
❑ Physician/Dentist _____ ❑ Other _____

Medical History

Does your child have or ever had any of the following diseases, conditions or procedures? (*Please circle Yes or No*)

Y N Autism/Autism Spectrum
Y N Asperger's Syndrome
Y N ADD/ADHD
Y N Behavioral, Emotional, or Communication Problems
Y N Intellectual Disability
Y N Impaired Hearing/Vision/Speech
Y N Eye Problems
Y N Acid Reflux/GERD
Y N Nutritional Deficiency
Y N Tonsils/Adenoids
Y N Cleft Lip/Palate
Y N Jaw Problems/TMJ
Y N Asthma
Y N Cystic Fibrosis
Y N Tuberculosis
Y N Thyroid Problems
Y N Jaundice/Hepatitis/Liver Problems
Y N Hemophilia
Y N Anemia
Y N HIV/AIDS/ARC
Y N Diabetes/Hypoglycemia
Y N Kidney Problems
Y N Brain Injury
Y N Cerebral Palsy
Y N Seizures/ Epilepsy
Y N Orthopedic Problems
Y N Scoliosis
Y N Artificial Bones/Joints/Implants
Y N Pregnancy
Y N Birth Defects
Y N Spina Bifida
Y N Latex Allergy
Y N High/Low Blood Pressure
Y N Congenital Heart Defect
Y N Heart Murmur
Y N Artificial Heart Valves
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Transplants
Y N Leukemia
Y N Chemotherapy/Radiation
Y N Cancer _____
Y N Syndrome _____
Y N Other _____

Does your child have any known drug allergies? ❑ Yes _____ ❑ No

Does your child currently take any medications (prescription/over the counter), including fluoride? ❑ Yes ❑ No

If Yes, please list medications: _____

Pediatrician: _____ Phone #: ( ) _____

Specialist: _____ Phone #: ( ) _____

Dental History

Is your child's water fluoridated? ❑ Yes ❑ No

If not, would you like a prescription for fluoride today? ❑ Yes ❑ No

Briefly describe your child's past dental experiences (If any): _____

Do you have any dental concerns? ❑ Yes ❑ No

If Yes, please explain: _____

Check current habits: ❑ Nail Biting ❑ Finger/Thumb Sucking ❑ Tooth Grinding ❑ Pacifier

Is your child under the care of an orthodontist? ❑ Yes _____ ❑ No

Were you referred to our practice by a physician/dentist? ❑ Yes _____ ❑ No

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

_____ Date: _____/_____/_____

Signature of Parent or Legal Guardian

Staff Initials: _____ Date: _____/_____/_____ Dr. Initials: _____

If your child has ever had a history of a heart condition, such as a heart murmur or any other medical condition that requires antibiotic premedication for dental visits, please contact your child's pediatrician or cardiologist prior to your scheduled appointment with us. Please ask the physician's office to fax a document to us stating whether or not antibiotic premedication is required. If needed, we ask that you have your physician prescribe the premed for your first appointment with us. Our fax number is (717) 741-9366.

CDCY™
CHILDREN'S DENTAL
CENTRE OF YORK

Angela S. Lutz, D.M.D.
David F. Laughlin, D.D.S.
Diplomates of the American Board of Pediatric Dentistry
Robert W. Bowser, D.M.D.

Financial Policy and Insurance

To provide the highest quality dental care, it is necessary to have a clearly defined financial policy.

As a courtesy to our patients, our billing and insurance department provides the following services:

- Verify coverage and confirm benefits with your dental insurance company
- Submit pre-treatment plans to your dental insurance company for accurate collection of co-payments at time of service
- Electronically submit or mail all dental claims on date of service

Due at time of service:

- If you do not have dental insurance, full payment is due at time of service
- If you have dental insurance, any amount that the insurance company does not pay us directly, is due at time of service.
- Co-payments are due at time of service

The parent or guardian bringing the patient is legally responsible for payment.

We accept the following methods of payment:

- 30 day payment arrangement (call for details)
- Cash
- Check
- Visa, MasterCard, Discover, and American Express
- Care Credit (apply online www.carecredit.com). We offer both 6 month and 12 month no interest through Care Credit with approval.

If you have any questions, please do not hesitate to contact our billing and insurance department @ 717-741-0848 option 5 during business hours, Monday – Thursday, 7:45 a.m. – 5:00 p.m.

Power of Consent Form
Children's Dental Centre of York

I, _____, parent or guardian of

_____, (DOB: ___/___/___)
_____, (DOB: ___/___/___)
_____, (DOB: ___/___/___)
_____, (DOB: ___/___/___)

I authorize the following individuals to perform stated tasks in my absence. (must be of age 18 years or old)

_____
Name relationship to patient

_____
Name relationship to patient

_____
Name relationship to patient

_____
Name relationship to patient

Tasks included in absence of authorized individual would be:

- schedule, reschedule, and/or confirm appointments by any means of communication (phone, e-mail, in person, etc…)
- escort patient(s) to appointments
- consent to treatment deemed medically necessary by dentist in our private practice at time of service (treatment to include x-rays, exams, cleanings, fluoride, extractions, crowns, spacers, sealants, pulpotomies, local anesthesia, nitrous oxide/oxygen sedation, etc…)

I am aware that any payment due at time of service will need to be paid either by the person escorting the patient or paid in advance via telephone by myself. I am aware that I can complete and or amend a new Power of Consent form anytime I wish to make changes.

_____
Signature of parent or guardian relationship to patient(s) Date

Request for Confidential Communication

Angela S. Lutz, D.M.D., LLC permits individuals to request and receive communications of personal health information from the practice by alternative means (such as a closed envelope instead of a post card) or at alternative locations (such as using a designated address or phone number).

I hereby request confidential communication relating to_____, (patient's name) regarding Protected Health Information ("PHI").

Name of Patient: _____ Patient I.D.#_____
Print

Patient DOB:_____

Patient Representative's Name _____
Print

Designated Method of Contacting the:

❑ **Patient**

❑ **Patient Representative**
relationship to the patient_____

(please describe below)

_____

_____

_____

Mailing Name:_____
Street Address:_____
City, State & Zip:_____

Telephone number(s) where messages can be left identifying the patient and/or provider:

_____ _____ _____
Home Number Work Number Cell Number

_____ _____
Signature of Patient / Patient Representative Date

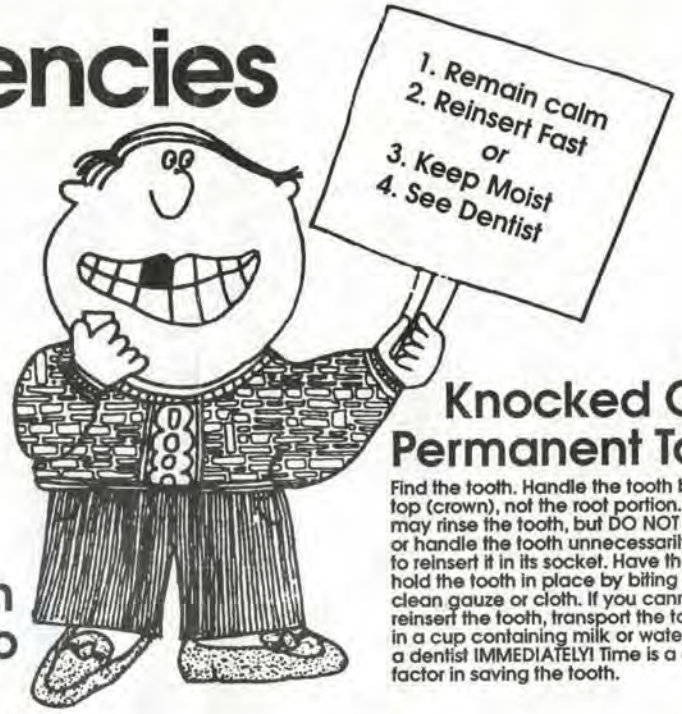
First Aid for Dental Emergencies

Toothache

Clean the area around the sore tooth thoroughly. Rinse the mouth vigorously with warm salt water or use dental floss to dislodge trapped food or debris. DO NOT place aspirin on the gum or on the aching tooth. If face is swollen, apply a cold compress. Take acetaminophen for pain and see a dentist as soon as possible.

Cut or Bitten Tongue, Lip or Cheek

Apply ice to bruised areas. If there is bleeding, apply firm but gentle pressure with a clean gauze or cloth. If bleeding does not stop after 15 minutes or it cannot be controlled by simple pressure, take the child to a hospital emergency room.



Knocked Out Permanent Tooth

Find the tooth. Handle the tooth by the top (crown), not the root portion. You may rinse the tooth, but DO NOT clean or handle the tooth unnecessarily. Try to reinsert it in its socket. Have the child hold the tooth in place by biting on a clean gauze or cloth. If you cannot reinsert the tooth, transport the tooth in a cup containing milk or water. See a dentist IMMEDIATELY! Time is a critical factor in saving the tooth.

Broken Braces and Wires

If a broken appliance can be removed easily, take it out. If it cannot, cover the sharp or protruding portion with cotton balls, gauze, or chewing gum. If a wire is stuck in the gums, cheek, or tongue, DO NOT remove it. Take the child to a dentist immediately. Loose or broken appliances which do not bother the child don't usually require emergency attention.

Other Emergency Conditions:

Possible Broken Jaw: If a fractured jaw is suspected, try to keep the jaws from moving by using a towel, tie, or handkerchief, then take the child to the nearest hospital emergency room.

Bleeding After Baby Tooth Falls Out: Fold and pack a clean gauze or cloth over the bleeding area. Have the child bite on the gauze with pressure for 15 minutes. This may be repeated once; if bleeding persists, see a dentist.

Cold/Canker Sores: Many children occasionally suffer from "cold" or "canker" sores. Usually over-the-counter preparations give relief. Because some serious diseases may begin as sores, it is important to have a dental evaluation if these sores persist.

Broken Tooth

Rinse dirt from injured area with warm water. Place cold compresses over the face in the area of the injury. Locate and save any broken tooth fragments. Immediate dental attention is necessary.

American Academy of Pediatric Dentistry