CDCY™
CHILDREN'S DENTAL
CENTRE OF YORK

Angela S. Lutz, D.M.D.
Amber L. Slevin, D.D.S.
David F. Laughlin, D.D.S.
Diplomates of the American Board of Pediatric Dentistry

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	7:30 a.m. - 4:45 p.m.
Tuesday	7:30 a.m. - 4:45 p.m.
Wednesday	7:30 a.m. - 4:45 p.m.
Thursday	7:30 a.m. - 3:30 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
P:(717) 741-0848 F:(717)741-9366 www.childrensdentalcentre.com

Angela S. Lutz, D.M.D.
Amber L. Slevin, D.D.S.
David F. Laughlin, D.D.S.
Diplomates of the American Board of Pediatric Dentistry

Financial Policy

With the complexity of dental plans available today, our experienced front desk staff can best serve you by providing the following information when calling to schedule an appointment –

- Name of parent who has effective dependent dental coverage, along with parent's –
- Date of birth
- Mailing address
- *Name of employer*
- Name of dental insurance company
- ID number or social security number

Understanding your dental insurance –

If your employer's human resource department has not explained the dental benefits that you have enrolled your dependents in, we would recommend that you call your dental insurance company directly.

Questions regarding deductibles, yearly maximums, percentage of coverage, and limitations of services such as radiographs and sealants can best be answered by your dental insurance company. They can also explain the difference between receiving dental care from an in-network provider vs. an out of network provider (CDCY is out of network) and how it may affect your out of pocket expense. Most insurance plans will provide out of network benefits.

We are happy to assist you by sending pre-treatment estimates for any services recommended by the dentist upon request. Once you receive your copy of the estimate, we would be happy to review it with you if you have any questions.

1399 South Queen Street, Suite A York, PA 17403
P:(717) 741-0848 F:(717)741-9366 www.childrensdentalcentre.com

What will I owe at time of service?

If your insurance company pays us directly, we will only ask for payment of the portion that the insurance company is not expected to pay.

If your insurance company pays the insured parent directly, we will ask for full payment.

If the patient is not insured or your insurance plan does not allow you to go out of network, we will ask for full payment.

Who is responsible for payment of services?

Whomever accompanies the patient for care is responsible for payment of services.

What type of payment do you accept?

- Cash
- Check
- Visa, Mastercard, Discover, and American Express
- Care Credit (We offer both 6 and 12 month no interest)
- 30 day deferred payment arrangements (call for details)

CDCY™
CHILDREN'S DENTAL CENTRE OF YORK

Angela S. Lutz, D.M.D.
Amber L. Slevin, D.D.S.
David F. Laughlin, D.D.S.
Diplomates of the American Board of Pediatric Dentistry

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 ______________

1399 South Queen Street, Suite A York, PA 17403
P:(717) 741-0848 F:(717)741-9366 www.childrensdentalcentre.com

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 or Food 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

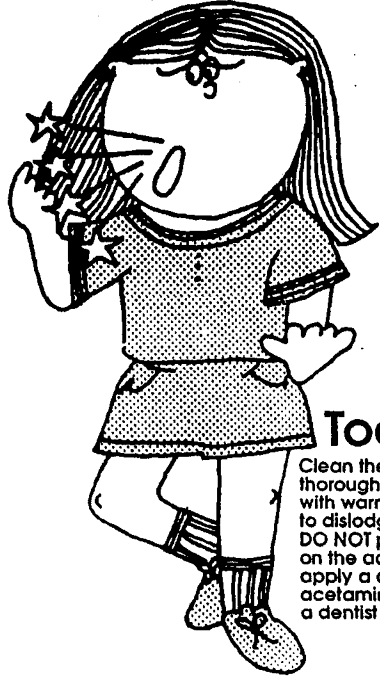
I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform the office of any changes to the information I have provided.

______________________________ Date: ____ /____ /____

Signature of Parent or Legal Guardian

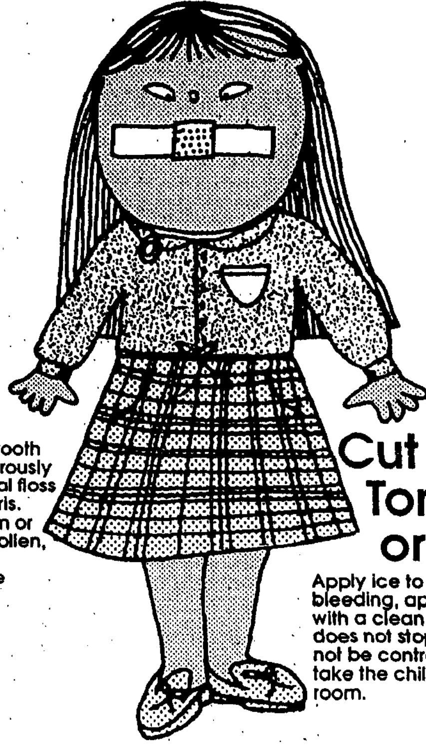
Staff Initials. ____________ Date: ____ /____ /____ Dr. Initials: ____________

First Aid for Dental Emergencies



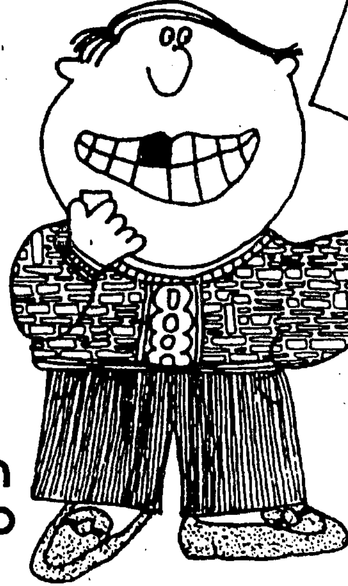
Toothache

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.



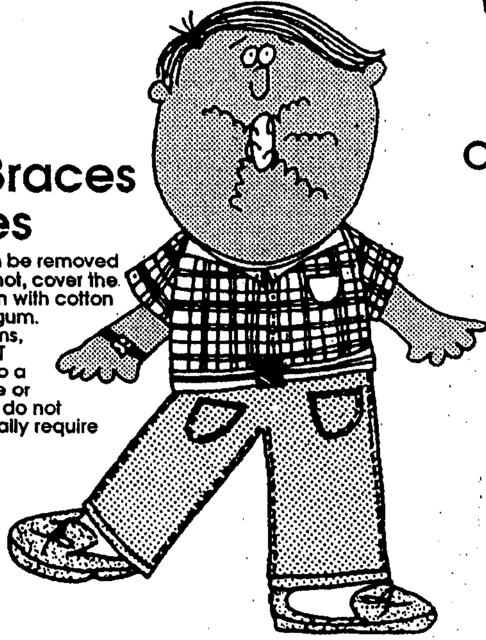
Cut or Bitten Tongue, Lip or Cheek

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

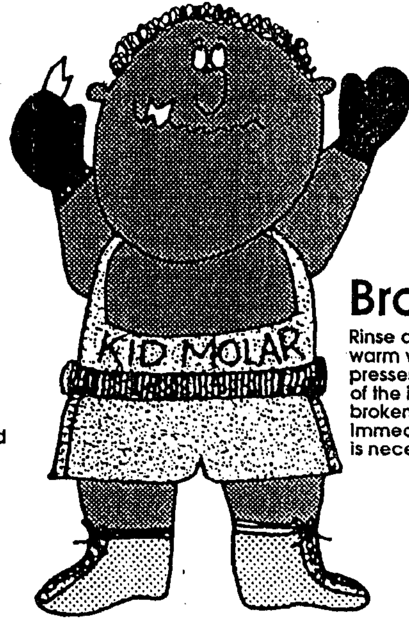
If a broken appliance can be removed easily, take it out. If it cannot, cover the sharp or protruding portion with cotton balls, gauze, or chewing gum. If a wire is stuck in the gums, cheek, or tongue, DO NOT remove it. Take the child to a dentist immediately. Loose or broken appliances which do not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

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.

Angela S. Lutz, D.M.D., LLC

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

© 2013 Total Compliance Solutions, Inc.

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

Angela S. Lutz, D.M.D., LLC

Patient Consent for Use of Electronic Mail

Please Print

Patient Name: ______________________________

Patient Address: ______________________________

Medical Record Number: ______________________________

Patient E-mail Address: ______________________________

1. RISK OF USING E-MAIL

Children's Dental Centre of York offers patients the opportunity to communicate with the practice and / or clinicians by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before giving consent. These risks include, but are not limited to:

a. E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.

b. E-mail can be immediately broadcast worldwide and be received by both intended and unintended recipients.

c. E-mail senders can misaddress e-mail.

d. E-mail can be more easily falsified than handwritten or signed documents.

e. Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

f. Employers and on-line services have a right to archive and inspect e-mails transmitted through their systems.

g. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.

h. E-mail can be used to introduce viruses into computer systems.

i. E-mail can be used as evidence in court.

© 2013 Total Compliance Solutions, Inc.

2. CONDITIONS FOR THE USE OF E-MAIL

Children's Dental Centre of York will use reasonable means to protect the security and confidentiality of e-mail information sent and received. However, because of the risks outlined above, Children's Dental Centre of York cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper disclosure of confidential information that is not caused by Provider's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent to the use of e-mail includes agreement with the following conditions:

a. All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's medical record. Because they are a part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those e-mails.

b. Children's Dental Centre of York may forward e-mails internally to Children's Dental Centre of York's staff and agents as necessary for diagnosis, treatment, reimbursement, and other handling. Children's Dental Centre of York will not, however, forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.

c. Although Children's Dental Centre of York will endeavor to read and respond promptly to e-mail from the patient, Children's Dental Centre of York cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for medical emergencies or other time-sensitive matters.

d. If the patient's e-mail requires or invites a response from Children's Dental Centre of York, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.

e. The patient should not use e-mail for communication regarding sensitive medical information, such as information regarding sexually transmitted diseases, AIDS/HIV, mental health, issues of abuse, developmental disability, or substance abuse.

f. The patient is responsible for informing Children's Dental Centre of York of any types of information the patient does not want to be sent by e-mail, in addition to those set out in (e) above.

g. The patient is responsible for protecting his/her password or other means of access to e-mail. Children's Dental Centre of York is not liable for breaches of confidentiality caused by the patient or any third party.

© 2013 Total Compliance Solutions, Inc.

h. Children's Dental Centre of York shall not engage in e-mail communication that is unlawful, such as unlawfully practicing medicine across state lines.

i. It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate by e-mail, the patient shall:

a. Limit or avoid use of his/her employer's computer.

b. Inform Children's Dental Centre of York of changes in his/her e-mail address.

c. Put his/her name in the body of the e-mail.

d. Include the category of the communication in the e-mail's subject line, for routing purposes (e.g., billing questions).

e. Review the e-mail to make sure it is clear and that all relevant information is provided before sending to the Provider.

f. Inform Children's Dental Centre of York that the patient received e-mail from Children's Dental Centre of York.

g. Take precautions to preserve the confidentiality of e-mails, such as using screen savers and safeguarding his/her computer password.

h. Withdraw consent only by e-mail or written communication to the Provider.

PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of e-mail between Provider and me, and consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that Provider may impose to communicate with patients by e-mail. Any questions I may have had were answered.

Patient Signature: ______________________________

Date: ______________________________

Witness Signature: ______________________________

Date: ______________________________

© 2013 Total Compliance Solutions, Inc.