ASSOCIATES IN PEDIATRIC DENTISTRY

Robert L. Delarosa, DDS • Bradley S. Comeaux, DDS • Paige Sigsworth, DDS • Brynn L. Leroux, DDS

WELCOME!!!!!!!

We are pleased that you have chosen our practice for your child's dental care. You and your child's comfort and satisfaction are our #1 priority. We are enclosing a general information form and a consent form. Please read and complete these forms (front and back) and bring them with you at the time of your appointment. Also we have enclosed our Acknowledgement of Receipt of Notice of Privacy Practices (HIPPA). This will save all of us some time at the initial appointment.

If you have any questions or concerns, please feel free to contact our office. Thank you again for the opportunity to provide your child with the best dental care.

Thank you,

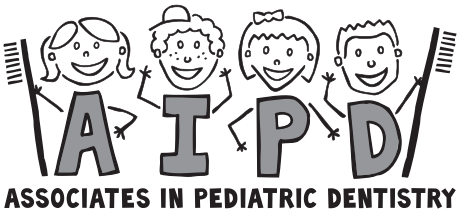
Associates in Pediatric Dentistry

4607 Sherwood Common Blvd., Bldg. 1
Baton Rouge, LA 70816
ph 225.924.6622 fx 225.926.3384

17534 Old Jefferson Hwy., Suite C1
Prairieville, LA 70769
ph 225.673.9600 fx 225.673.9639

13375 LA Hwy. 73, Suite B
Geismar, LA 70734
ph 225.673.9898 fx 225.673.4380

149 Del Orleans Ave.
Denham Springs, LA 70726
ph 225.667.9899 fx 225.665.7895



ASSOCIATES IN PEDIATRIC DENTISTRY

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

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your child's health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your child's health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect March 31, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the 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.

You may request a copy of our Notice at any time. For more information abut 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 your child for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your child's health information to a physician or other healthcare provider providing treatment to your child.

Payment: We may use and disclose your child's health information to obtain payment for services we provide to you and your child.

Healthcare Operations: We may use and disclose our health information in connection with our healthcare operations. Healthcare operations include 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 credential activities.

Your Authorization: In addition to our use of your child's health information for treatment, payment or healthcare operations, you may give us written authorization to use your child's 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 child's health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your child's health information to you, as described in the Patient Rights section of this Notice. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for your child's healthcare, but only if you agree that we may do so.

Person's 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 child's personal representative or another person responsible for your child's care, or your location, your general condition, or death. If you are present, then prior to use or disclosure or your child's 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 and our experience with common practice to make reasonable inferences of your child's 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 will not use your child's health information for marketing communications without your written authorization.

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

Abuse or Neglect: We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your child's health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your child's health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your child's health information. You may obtain a form to request access by using the contact information listed at the end of the Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of the Notice. If you request copies, we will charge you $.50 for each page, $10.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your child's health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your child's health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your child's health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your child's privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your child's health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U. S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U. S. Department of Health and Human Services upon request.

We support your right to the privacy of your child's health information. We will not retaliate in any way if you choose to file a complaint with us or with the U. S. Department of Health and Human Services.

Contact Our Office at: (225) 924-6622

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ASSOCIATES IN PEDIATRIC DENTISTRY

GENERAL INFORMATION AND CONSENT

We are pleased to receive your child as a patient in our office and feel honored by the confidence you have placed with us. We sincerely desire to make his or her visits as pleasant as possible. We feel that we can better establish patient-doctor relationships if our parents and patients are familiar with the services and procedures of this office.

INITIAL VISIT: Each child receives a thorough examination on their first appointment. It usually includes a prophylaxis (cleaning of the teeth), topical fluoride, and dental x-rays, if they are needed. Oral hygiene instructions will be given to the patient and reviewed with the parent along with dietary recommendations. We employ all procedures available to reduce radiation risk including thyroid and gonadal lead apron, collimated x-ray machine, and the fastest film available today. We feel that it is extremely important for a child to have a full mouth x-ray (panorex) starting around the age of 7 to check for any problems such as extra permanent teeth, congenitally missing teeth, cysts, or eruption problems.

PARENTS MAY ACCOMPANY THEIR CHILD: We have an open door policy in our practice. We want our parents to participate in their child's dental education and feel that it is important that they support our recommendations. We feel that we can prevent most of your child's dental problems with a team effort.

NITROUS OXIDE (LAUGHING GAS): Frequently, we will employ the "Happy Air Mask" (nitrous oxide) to help reduce anxiety and fear of dental procedures. It is tremendously effective when treating children and is very safe.

PREMEDICATION: It is sometimes necessary to premedicate young children with sedatives in order to successfully perform certain dental procedures. If we recommend premedication, the medications and anticipated side effects will be carefully explained before the procedure. Children who have been premedicated will have their vital signs monitored throughout the procedure.

HOSPITALIZATION: Some young or handicapped children requiring extensive treatment would benefit by having their work done under general anesthesia in the hospital setting. If we feel that this is a necessary way to treat your child, we will thoroughly discuss hospitalization with you.

PREVENTIVE DENTISTRY: Since some areas of Southeast Louisiana are not adequately fluoridated, preventive dentistry is extremely important. The American Academy of Pediatric Dentistry recommends that children who live in non-fluoridated areas routinely take fluoride supplements (Poly-vi-flor, Luride, Phos-flur, etc.) until the age of ten. Fluoride helps strengthen the teeth as they develop. Also, home fluoride rinse is recommended to strengthen the teeth that are presently in the mouth. We highly recommend sealants for the permanent molars and some second primary molars after eruption.

ORTHODONTICS: At each six month hygiene appointment your child will be checked for proper eruption of teeth and/or any malocclusion that may be developing. We will inform you of any treatment that we feel is necessary for your child.

CHILDREN'S TIME: Although we schedule appointment times for the treatment of your child, our office operates on "children's time". This means that occasionally some of our patients who are not particularly interested in getting their dental work done may take extra time to be made more comfortable and less apprehensive. This will invariably play havoc with our schedule and cause some delays. So let me personally apologize for running behind now! We are guilty of letting our patients manipulate the schedule somewhat when we are trying to give them the best possible dental experience. We also see many emergencies since children may have accidents at home, school or play.

APPOINTMENT POLICY: As a growing pediatric dental practice, our schedule is sometimes booked several months in advance. While we understand that some appointments can't be kept, we would like the courtesy of a phone call notifying us so that we may give that appointment to another child.

PLEASE LET US KNOW IF YOU OBJECT TO THE USE OF FLUORIDE, AND/OR X-RAYS.
We intend to render dental services to your child as we would our own. If at any time you have questions concerning your child's dental health, please feel free to ask us.

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I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS FORM

Parent's Signature _____ Child's Name_____

Reviewed by _____ Date _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to sign This Acknowledgment**

I, _____, have received a copy of this office's Notice of Privacy Practices on behalf of my child/children.

_____
Parent Name

_____ _____
Signature Date

_____
Child/Children's Name(s)

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

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

_____

_____

_____

Please check any information that is pertinent to your child.

Child's interests and hobbies: _____

Medical History

	Yes	No
Is your child in good health?	_____	_____
Does your child have regular medical exams?	_____	_____
Is your child up to date with immunizations?	_____	_____
Is your child taking any medications?	_____	_____
If so, please list _____		
Has your child had any unfavorable reactions to any medications?	_____	_____
If so, please list _____		
Has your child had any surgeries and/or hospitalizations?	_____	_____
If so, please list _____		
Was your child full term at birth?	_____	_____
If No: Born at _____ weeks.		
Admitted to the NICU? yes___ no___ How long? _____		
Intubated? yes___ no___ How long? _____		
Child's Physician _____		

Dental History

	Yes	No
Is this your child's first dental visit?	_____	_____
If not, date of last visit _____		
Has your child had an unfavorable experience at another dental office?	_____	_____
Is your child presently on a fluoride supplement?	_____	_____
Is your child a finger sucker?	_____	_____
Does your child use a pacifier?	_____	_____
Has your child ever experienced trauma to the teeth, face, or jaw?	_____	_____

Age the bottle was discontinued _____

What is your water source?

Private Well _____ Public System _____

Parish where water source is located?

_____

Please check if your child has any of the following:

_____ ADD / ADHD
_____ Allergies
_____ Asthma
_____ Autism
_____ Bleeding Disorder
_____ Brain Disorder
_____ Cancer
_____ Cerebral Palsy
_____ Diabetes
_____ Down Syndrome
_____ Emotional Disorder
_____ Epilepsy
_____ Hearing Disorder
_____ Heart Condition
Type _____
_____ Antibiotic Required
_____ Hepatitis
_____ HIV+
_____ Kidney Disorder
_____ Latex Allergy
_____ Leukemia
_____ Liver Disorder
_____ Mental Condition
_____ Nervous Disorder
_____ Recurrent Headaches
_____ Developmental Delay
_____ Rheumatic Fever
_____ Sickle Cell Anemia
_____ Speech Disorder
_____ Spina Bifida
_____ Transfusions
_____ Tuberculosis
_____ Vision Disorder
_____ Other:
_____
_____

Reason for Today's Appointment

Cleaning and Exam _____ Exam Only _____ Crowding Evaluation _____

Toothache _____ 2nd Opinion _____

Other _____

PERMISSION:

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all dental services can be performed by Dr. Robert Delarosa, Dr. Bradley S. Comeaux, Dr. Paige Sigsworth, Dr. Brynn L. Leroux and/or their associates. Authorization is hereby granted to Dr. Robert Delarosa, Dr. Bradley S. Comeaux, Dr. Paige Sigsworth, Dr. Brynn L. Leroux and/or their associates and shall remain in force and effect until cancelled by either party. I hereby assign all dental services rendered to AIPD. I understand and accept responsibility for any services not covered by insurance, including co-payments, co-insurance, and non covered amounts.

Signed _____ Relationship _____ Date _____

Robert L. Delarosa, DDS, LLC • Bradley S. Comeaux, DDS • Paige Sigsworth, DDS • Brynn L. Leroux, DDS

Patient Information

Date _____ Nickname _____ Birthdate _____ Sex _____

Patient's Name _____ Social Security # _____
Last First Middle

Address _____
Street City State Zip

Primary Phone _____ School Child Attends _____

Primary Language _____

If patient is a minor, give parent's or legal guardian's name _____

Other children in your family that we have seen _____

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

Responsible Party Information

Legal Guardian/Parent Name _____ _____
Last First Middle Marital Status

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

Email Address to Confirm Appointments _____

How long at this address _____ Home Phone _____ Cell _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Legal Guardian/Parent Name _____ Relationship to Patient _____
Last First Middle

Employer _____ Occupation _____ No. Years Employed _____

Social Security # _____ Birthdate _____ Cell Phone _____

Dental Insurance Information

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Do you have dual coverage? ☐ Yes ☐ No If Yes:

Insured's Name _____ Insured's Soc. Sec. # _____

Insurance Company _____ Group No. _____ Local No. _____

Insurance Co. Address _____

Insured's Employer _____

Emergency Information

Name of nearest relative not living with you _____ PHONE _____

_____ _____
Signature (Parent's signature if patient is a minor) Updates (date & initial)

CONFIDENTIAL (for record and pretreatment evaluation)