ABOUT OUR OFFICE

APPOINTMENT TIMES

Our office makes every attempt to make scheduling your child's appointment as easy as possible. We have implemented a few guidelines in order to accommodate the majority of our patients.

Cleaning Appointments:
All children 6 years old and under will always be seen in the morning. This includes all children in kindergarten and preschool. This will allows us to see older patients in the afternoon time when it is more important not to miss school.

Filling Appointments:
Generally, children 8 years old and younger will be seen in the morning for filling appointments. The purpose for this is, children of this age tend to be too tired for late day appointments and do not handle the treatment as well. Also the office tends to be a bit slower in the morning which allows extra time for children that might be fearful.

Promptness:
Please schedule times that you are able keep. Many of our parents schedule after school appointments in which they wait for their child to get home from the bus or do not factor after school traffic. This often results in our patients arriving 10 to15 minutes late. The result is our schedule not running as assigned which is unfair to patients who arrive on time. Please take the appropriate measures to see that your child arrives on time to their visit. As a general rule patients that arrive more than 10 minutes late may not be seen.

DENTAL X-RAYS

We follow the guidelines established by the American Academy of Pediatric Dentistry for all treatment. We do not take dental x-rays every year just for the sake of it. Each child is treated as an individual, if your child has a dental decay history we tend to take them every year. If your child has no dental decay than we tend to take x-rays every 18 months to 24 months.

If you are present with your child we will always ask before we take dental x-rays. If you are not present with your child (a grand parent, family member or older sibling brings your child) we will update your child's x-rays if they are deemed necessary.

PAYMENT AND INSURANCE

Payment is expected at the time of treatment. Payments may be made by cash, check or credit card. If you are covered by a insurance plan any portion not covered by your insurance is expected at the time of treatment including deductibles and/or patient portions. Any account balance 60 days old will be subject to a finance charge of 1.5 % per month (18% per year) on the unpaid balance.

Pediatric Dental Associates is not responsible for the determination of benefits provided by your insurance company. Currently we estimate that we accept approximately one thousand insurance plans. Our office will make every effort to help you with your benefits. If your insurance carrier does not allow for the payment of a particular treatment than you will be responsible for the payment. If your company only recognizes a percentage of our fee you will be responsible for the difference.

NOTICE OF PRIVACY PRACTICES

Our office follows all HIPAA regulations concerning the confidentiality of patient records and information.
I have received a copy of this office's Notice of Privacy Practices, and give consent for the use and disclosure of health information to carry out treatment, payment activities and healthcare operations.

I the under signed have read and understand the policies and practices of Pediatric Dental Associates

_____

Your signature **Date**

Pediatric Dental Associates Health Form

Child's Name: _____ Nickname: _____ Gender: ☐ M ☐ F ☐ Nonbinary
Age:_____ Birth Date: _____ Pronouns: _____ Hobbies/Interests/Pets: _____
Mailing Address: _____ City:_____ State: ___ Zip: _____
Home Telephone: _____ Cell Phone: _____ Email: _____
Whom may we thank for referring you? _____

Child's Physician/Pediatrician: _____ Phone: _____
Address: _____ Child's Previous Dentist: _____

Do you have any concerns about your child's teeth? _____

Medical History

Were there any difficulties during the pregnancy, delivery (e.g. prematurity) or 1st year of your child's life? ☐ Yes ☐ No
If yes, describe. _____
Was your child bottle fed? ☐ Yes ☐ No If yes, until what age? _____ Any difficulty with bottle feeding? ☐ Yes ☐ No
Was your child breast fed? ☐ Yes ☐ No If yes, until what age? _____ Any difficulty latching? ☐ Yes ☐ No
Has your child had any frenectomies? ☐ Yes ☐ No If yes, date and provider: _____

Does your child have any history of the following? (*Check all that apply.)*

☐ ADHD	☐ Anemia	☐ Anxiety/Nervousness	☐ Arthritis/Bone/Joint Issues	☐ Asthma/Reactive Airway
☐ Autism	☐ Behavior Issues	☐ Bladder/Kidney Issues	☐ Bleeding (prolonged)	☐ Blood Transfusion
☐ Brain Injury/Stroke	☐ Cancer _____	☐ Cerebral Palsy	☐ Cleft Lip/Palate	☐ Communication Issues
☐ COVID-19/RSV	☐ Cystic Fibrosis	☐ Developmental Delay	☐ Diabetes	☐ Ear Infections/Ear Tubes
☐ Emotional Disability	☐ Feeding Problems	☐ Gastrointestinal Disorders (Celiac/Crohn's, GERD)		☐ Growth Problems
☐ Headaches/Migraines	☐ Hearing Loss	☐ Heart Disease	☐ Heart Murmur	☐ Hemophilia
☐ Hepatitis/Jaundice	☐ HIV/AIDS	☐ Learning Disability	☐ Neuromuscular Defects	☐ Orthopedic Problems
☐ Psychiatric Disorder	☐ Rheumatic Fever	☐ Scarlet Fever:	☐ Seizures/Epilepsy	☐ Sensory Integration
☐ Sickle Cell Disease/Trait	☐ Sinus/Adenoids/Tonsils	☐ Skin (Eczema/Rash/Hives)	☐ Sleep Apnea	☐ Sleep Problems/Snoring
☐ Speech Problems	☐ Spina Bifida	☐ Thyroid disorder	☐ Tobacco/Vaping/Drug use	☐ Tuberculosis
☐ Syndrome: _____		☐ Other: _____		☐ Abuse (physical/sexual)

If any boxes are checked, please describe further: _____
_____
_____

Is your child CURRENTLY taking any medications? ☐ Yes ☐ No

Drug	*Dose*	*Frequency*	*Reason*

Has your child had any allergic reactions to: Medications? ☐ Yes ☐ No _____ Latex? ☐ Yes ☐ No
Foods? ☐ Yes ☐ No _____ Other? _____

Development/Special Needs:
Can your child speak and understand at his/her age level? ☐ Yes ☐ No
Does your child attend a special class or school? _____ ☐ Yes ☐ No
Are your child's immunizations current? ☐ Yes ☐ No

Does your child need to take antibiotics before dental treatment? ☐ Yes ☐ No

Has your child ever been hospitalized? ☐ Yes ☐ No
When? _____ Where? _____ Reason? _____

Has your child had any surgery? ☐ Yes ☐ No
When? _____ Why? _____ Was general anesthesia used? ☐ Yes ☐ No
Any complications? _____

Dental History

Why is your child here today? _____

If your child has been to a dentist: Date of last visit _____ Have X-rays been taken? ☐ Yes ☐ No ☐ Unsure
How did your child react? _____

How would you describe your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Is there a family history of cavities? ☐ Yes ☐ No If yes, indicate all that apply: ☐ Mother ☐ Father ☐ Sibling

Is fluoride taken in any of the following forms?
Fluoride tablets, drops, or multivitamins ☐ Yes ☐ No Drinking water ☐ Yes ☐ No
Toothpaste ☐ Yes ☐ No Fluoride rinse ☐ Yes ☐ No

How often do your child's teeth get brushed? # of times/day _____ Does someone help your child brush? ☐ Yes ☐ No
When does your child brush? ☐ AM ☐ PM ☐ After meals
How often do your child's teeth get flossed? # of times/day _____ Does someone help your child floss? ☐ Yes ☐ No
What kind of toothbrush does your child use? ☐ Manual ☐ Battery-powered/Electric
What toothpaste does your child use? _____
Does your child swallow toothpaste? ☐ Yes ☐ No ☐ Unsure

Does your child regularly eat 3 meals each day? ☐ Yes ☐ No
Does your child snack frequently? ☐ Yes ☐ No # of times/day _____
What does your child typically snack on? _____
Is your child on a special or restricted diet? ☐ Yes ☐ No Describe: _____
Is your child a picky eater? ☐ Yes ☐ No
Is your child a slow eater? ☐ Yes ☐ No
Does your child drink juice? ☐ Yes ☐ No How much? _____
Does your child drink soda? ☐ Yes ☐ No How much? _____
Does your child drink seltzer or flavored water? ☐ Yes ☐ No How much? _____
Does your child drink sports drinks? ☐ Yes ☐ No How much? _____
Does your child drink energy drinks or coffee? ☐ Yes ☐ No How much? _____
Does your child chew gum? ☐ Yes ☐ No Is it sugar free? ☐ Yes ☐ No ☐ Unsure

Have your child's teeth ever been injured? ☐ Yes ☐ No When (age)? _____
Which teeth? _____ Injury? _____
Treatment? _____

Does your child have any of the following habits? (Please check all that apply)
☐ Pacifier ☐ Thumb Sucking ☐ Finger Sucking ☐ Grinding ☐ Snoring
☐ Mouth Breathing ☐ Tongue Thrust ☐ Lip Sucking ☐ Open Mouth Posturing ☐ Nail Biting
☐ Excessive Gagging ☐ Holding Food in Mouth ☐ Bottle to Sleep or Nap ☐ Walking Around with a Sippy Cup or Bottle

Has your child had any unhappy dental experiences? ☐ Yes ☐ No Please explain. _____
_____

Is there anything else you'd like to tell us? _____
_____

Parent Signature: _____ Relationship to Patient: _____ Date: _____

Reviewed by:_____

Pediatric Dental Associates – Insurance Information

Accepted: In-Network Insurance

1. Altus
2. Altus-HNE
3. Altus-EHB
4. BC/BS Dental Blue, BC/BS Federal, BC/BS HMO Blue
5. Blue Cross Blue Shield
6. Delta Dental PPO (PPO only, not EPO)
7. Delta Preferred

Accepted: Out of Network

1. Aetna
2. Aetna PPO
3. Aflac
4. Alicare
5. Ameritras Group Dental
6. Cigna
7. CT Pipe Trades Health Funds
8. GEHA
9. Guardian
10. Harvard Pilgrim
11. Lincon Financial Group
12. MetLife
13. Principal
14. Sun Life Financial
15. UMR
16. Unicare
17. United Health Care

Is your insurance not listed? Please call your provider and ask if you can go out of network

Not Accepted: Please call the office if you have any questions

1. Mass Health
2. Aetna DMO
3. Anthem Blue Cross Blue Shield
4. Big Y Cigna DPPO
5. Delta Dental EPO
6. Mass Public Employees Delta Dental Closed Plan
7. Tricare/United Concordia

PEDIATRIC DENTAL ASSOCIATES

General Parent Information

The child lives with ( ) both parents ( ) parent 1 ( ) Parent 2 ( ) Other

PARENT/GUARDIAN 1
( ) Father
( ) Mother
( ) Other
_____

NAME_____
SSN_____ DOB_____
STREET_____
CITY_____STATE_____ZIP_____
Home Phone:_____CELL:_____
Occupation:_____
Employer:_____
Business Address:_____
Business Phone:_____

PARENT/GUARDIAN 2
( ) Father
( ) Mother
( ) Other
_____

NAME_____
SSN_____ DOB_____
STREET_____
CITY_____STATE_____ZIP_____
Home Phone:_____CELL:_____
Occupation:_____
Employer:_____
Business Address:_____
Business Phone:_____

DENTAL INSURANCE INFORMATION

Primary Insurance _____
Employer_____Employee_____
Group Number_____Subscriber Number_____
Secondary Insurance_____
Group Number_____Subscriber Number_____

MEDICAL INSURANCE INFORMATION
Insurance Company_____
Employer_____Employee_____
Group Number_____Subscriber Number_____

IN ORDER TO COMPLY WITH MOST INSURANCE COMPANIES, WE ASK THAT YOU SIGN BELOW SO THAT WE MAY KEEP YOUR SIGNATURE ON FILE. I HAVE REVIEWED THE FOLLOWING TREATMENT PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO PEDIATRIC DENTAL ASSOCIATES.

Signature_____Date_____

Pediatric Dental Associates HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Bill for your services
- Comply with the law
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Pediatric Dental Associates HIPAA Notice of Privacy Practices (p2)

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Substance Use Disorder (SUD) Records cannot be used in civil, criminal, or administrative proceedings without written consent or a court order.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Notice of Rights Concerning Substance Use Disorder Records

- If we create or maintain substance use disorder (SUD) records covered by 42 CFR part 2 (Part 2), we must ensure that an individual who is the subject of records protected under 42 CFR part 2 receives adequate notice of the uses and disclosures of such records, and of the individual's rights and the covered entity's legal duties with respect to such records.
- [SUD] treatment records received from programs subject to 42 CFR part 2, or testimony relaying the content of such records, shall not be used or disclosed in civil, criminal, administrative, or legislative proceedings against the individual unless based on written consent, or a court order after notice and an opportunity to be heard is provided to the individual or the holder of the record, as provided in 42 CFR part 2. A court order authorizing use or disclosure must be accompanied by a subpoena or other legal requirement compelling disclosure before the requested record is used or disclosed.
- If the permissible uses or disclosures of information described in the NPP are limited by other laws that are more restrictive than HIPAA (*e.g.*, SUD records protected by Part 2), the description of such uses or disclosures must reflect the more stringent law.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, caregivers, or others involved in your care
- Share information in a disaster relief situation

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

In the case of fundraising:

- While we don't engage in fundraising, we are required to inform you that if we do intend to use or disclose such records for fundraising for the benefit of the patient, the individual must first be provided with a clear and conspicuous opportunity to elect not to receive any fundraising communications.
- Patients may opt out of fundraising communications related to SUD records.

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

We can use your health information and share it with other professionals who are treating you.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information. Once PHI (including SUD-related PHI) is disclosed, it may lose federal protection upon redisclosure.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

- Effective Date: 2/16/26
- Pediatric Dental Associates, Dr. Laurie M. Brown, Pediatric Dentistry, P.C., 52 North Main St. East Longmeadow, MA 01028, (413) 525-6626
- We never market or sell personal information. We will never share any substance abuse treatment records without your written permission.