Lil Pearls
Pediatric Dentistry

FAMILY REGISTRATION FORM

We are pleased to welcome you and your child to our practice. Please take a few minutes and fill ***out one per family****. If you have any questions, we are glad to help!*

Date:_____

Child(ren)'s Information

Name: _____ Date of birth (mm/dd/yyyy): _____
Name: _____ Date of birth (mm/dd/yyyy): _____
Name: _____ Date of birth (mm/dd/yyyy): _____
Name: _____ Date of birth (mm/dd/yyyy): _____
Child(ren)'s Home Address: _____ Apt/Unit: _____
City: _____ State: _____ ZIP Code: _____

Who is accompanying the child(ren) today?

Name: _____ Relationship to Patient: _____ Legal custody? o Yes o No
How did you hear about us? o Friend or family member _____ o Physician _____ o Insurance
o Dentist presentation o Community fair o Practice website o Internet search o Other _____

Parental Information

o Mother o Step mother o Legal guardian o Father	o Father o Step father o Legal guardian o Mother
Name: _____ Birthdate: _____	Name: _____ Birthdate: _____
Home #: _____ Work #: _____	Home #: _____ Work #: _____
Mobile #: _____ SSN: _____	Mobile #: _____ SSN: _____
Email: _____	Email: _____
Occupation: _____	Occupation: _____
Status: o Single o Married o Divorced o Partnered	Status: o Single o Married o Divorced o Partnered

Dental Insurance Information

Primary Insurance Co. Name: _____	*Secondary* Insurance Co. Name: _____
Insurance Co. Address: _____	Insurance Co. Address: _____
_____	_____
Insurance Co. Phone: _____	Insurance Co. Phone: _____
Subscriber ID #: _____	Subscriber ID #: _____
Group Name: _____ Group #: _____	Group Name: _____ Group #: _____
Policy Owner's Name: _____	Policy Owner's Name: _____
Relationship to patient: _____	Relationship to patient: _____
Policy Owner's Birthdate: _____ SSN: _____	Policy Owner's Birthdate: _____ SSN: _____
Policy Owner's Employer: _____	Policy Owner's Employer: _____

Authorization for a <u>Babysitter/Grandparent/Non-parent/Family Member</u> over 18 years old to bring my child in for treatment:
If a parent/legal guardian is unable to bring the child(ren) for treatment, I, _____, the
o Mother o Father o Legal guardian of _____, authorize the adult(s) listed below to accompany my child(ren) and provide consent for all treatments including, but not limited to: exams, cleanings, x-rays, restorations, endodontic treatment, crowns and nitrous oxide. A separate consent must be signed by a legal guardian for extractions and use of medical immobilization. This authorization will remain in effect until such time as I give notice of its termination.

Adult authorized to accompany child(ren): _____
Relationship to child(ren)/family: _____ Phone #: (_____) _____ - _____
Adult authorized to accompany child(ren): _____
Relationship to child(ren)/family: _____ Phone #: (_____) _____ - _____

Lil Pearls
Pediatric Dentistry

PATIENT MEDICAL AND DENTAL HISTORY FORM

*We are pleased to welcome you and your child to our practice. Please take a few minutes and fill out one for **each child** being treated at our office. If you have any questions, we are glad to help!*

Date: _____

PATIENT INFORMATION

Child's Full Name: _____ Nickname: _____ Sex: o Male o Female

Date of birth (mm/dd/yyyy): _____ Age: _____ SSN: _____

Hobbies, pets, favorite TV shows, etc.: _____

PHYSICIAN INFORMATION

Primary physician (name and office): _____ Phone number: _____

Medical specialists (name and office): _____ Phone number: _____

Date of last physical exam (mm/yyyy): _____ Any significant results? _____

Please be as accurate as possible with your child's health history. Certain medical conditions, medications and allergies may affect dental treatment and may require a consultation from your child's physician or specialist.

MEDICAL HISTORY

Is your child being treated by a physician at this time? Reason: _____ o Yes o No

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? o Yes o No

If yes, please list: _____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? o Yes o No

List date and describe: _____

Has your child ever had an allergic reaction or a problem with the following? o Yes o No

- o Medications? _____
- o Latex, metals, acrylic or dye? _____
- o Foods? _____
- o Seasonal or other? _____

Is your child up to date on immunizations against childhood diseases? o Yes o No

Does your child have any physical, mental, or developmental impairment? o Yes o No

If yes, describe: _____

Have you ever been told your child has a heart murmur or other heart condition? o Yes o No

If yes, describe: _____

If yes, were you told your child requires antibiotic prophylaxis before dental appointments? o Yes o No

Please review carefully and check if your child has any history of, or condition related to, any of the following:

o Anemia	o Cerebral Palsy	o Fainting	o Liver/Hepatitis	o Speech/Hearing disorders
o Arthritis	o Chicken Pox	o Growth problems	o Measles	o Skin
o Asthma	o Chronic sinusitis	o Headaches	o Mononucleosis	o Thyroid
o Autism	o Congenital Defects	o Heart conditions	o Mumps	o Tobacco/Drug Use
o Bladder/Kidney	o Cystic Fibrosis	o Heart murmur	o Rheumatic Fever	o Tuberculosis
o Bleeding disorders	o Diabetes	o HIV/AIDS	o Seizures/Epilepsy	o STD
o Bone disorders	o Ear aches/Infection	o Hyperactivity	o Sickle Cell	o Vision disorders
o Cancer/Tumors	o Enlarged tonsils	o ADHD/ADD	o Snoring	o **NONE**

If any of the above items were checked, please provide details here: _____

_____

Is there any other medical condition pertaining to this child that the dentist should be informed of? o Yes o No

If yes, describe: _____

Lil Pearls
Pediatric Dentistry

DENTAL HISTORY

What is the reason for this visit? _____

Has your child been treated by another dentist? ○ Yes ○ No

If yes, by _____ Phone number: _____

Date of first visit: _____ Date of last visit: _____ Treatments performed: _____

If x-rays were taken, what was the date of the most recent dental x-rays? _____

Did your child have an unfavorable experience or reaction? _____

Have there been any injuries to your child's mouth, teeth, or head? _____

What type of water does your child drink (select the most frequent)? ○ City water ○ Bottled water ○ Filtered water

Does your child take fluoride supplements/vitamins? ○ Yes ○ No

How often does your child brush his/her teeth? ____ times per _____ Does someone supervise? ○ Yes ○ No

Does your child brush with a fluoridated toothpaste? ○ Yes ○ No

How often does your child floss his/her teeth? ○ None ○ Occasionally ○ Daily Does someone supervise? ○ Yes ○ No

Please check if your child has any of the following mouth habits:

○ Thumb/digit sucking ○ Pacifier ○ Breastfeeding at night ○ Sleeping with bottle/sippy cup ○ Other: _____

Is your child on a special or restricted diet? ○ Yes ○ No

If yes, describe: _____

How frequently does your child have the following?

Candy or other sweets: ○ Rarely ○ 1-2 times/day ○ 3 or more times/day Product _____

Snacks between meals: ○ Rarely ○ 1-2 times/day ○ 3 or more times/day Usual snack _____

Juice, soda, sports drinks: ○ Rarely ○ 1-2 times/day ○ 3 or more times/day Product _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ○ Yes ○ No

If yes, by whom and describe: _____

Is there anything else we should know before treating your child? _____

AUTHORIZATION AND CONSENT

I certify that I am the parent, legal guardian, or personal representative of (name of patient) _____ and there are no court orders now in effect that prohibit me from signing this consent. As this child's parent, legal guardian, or personal representative, I acknowledge that the information I have given is complete and correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform the office of any changes in my child's medical status. I understand that misrepresenting or withholding medical/dental information can be harmful to my child during dental treatment.

I do hereby authorize the dental staff to perform an oral examination (including any necessary x-rays and photos) and after explanation, any and all treatment for the above named child. I consent to such methods, drugs/anesthetics, and agents that may be indicated and deemed advisable by the doctor in connection with my child's dental care, whether or not I am present when the treatment is rendered.

I authorize my insurance company to pay Lil Pearls Pediatric Dentistry PLLC all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I agree to be financially responsible for all charges for services rendered, any deductible, and any co-payment on my behalf or my dependents, whether or not it is covered by my insurance company, and that all payments are due when services are rendered.

I hereby authorize Lil Pearls Pediatric Dentistry PLLC to release any information, including the diagnosis and the record of any treatment or examination, rendered to my child during the period of such dental care to third party payors and/or other health practitioners.

This consent shall remain in full force and in effect until cancelled in writing.

_____ _____

Signature of parent, legal guardian, or personal representative Date

_____ _____

Please print name of parent, legal guardian, or personal representative Relationship to patient

CONSENT FOR TREATMENT

TREATMENT

I am aware that dental treatment will be rendered by Dr. Jeffrey Fong, a licensed practitioner in the specialty of pediatric dentistry, as well as trained dental auxiliaries. I consent to treatment as indicated by sound and prudent dental practices that are diagnosed or discovered during the course of my child's dental care. The nature and purpose of the treatment to be rendered will be explained to me and no guarantee will be made that the results will be to my complete satisfaction although it is believed that such results will be satisfactory.

I agree to the use of topical and local anesthetic agents as indicated for my child's dental treatment, if warranted. I further consent to the taking of radiographs (x-rays), photographs, and impressions when they are indicated for the purpose of diagnosing and planning treatment. I understand the office employs the use of digital radiography, and adopts the philosophy "As Low As Reasonably Achievable (ALARA)" in its approach to dental x-rays in children. I expressly agree that the office may use such materials for educational and scientific purposes including seminar instruction, publication of literature, and demonstration of methods and techniques of pediatric dentistry. I understand that suitable measures will be taken to maintain my child's anonymity. I understand that all original dental records are the property of Lil Pearls Pediatric Dentistry and cannot be taken or sent from this office. Copies of dental records will be provided upon written or verbal request of a dentist, physician, parent, or legal guardian.

It is unusual for any of the following risks or complications to occur. These risks or complications include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

BEHAVIOR MANAGEMENT TECHNIQUES

I understand it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion, humor, charm, gentleness and kindness and understanding. I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

I authorize the doctor and staff of Lil Pearls Pediatric Dentistry to use its judgment to decide when particular behavior management techniques would be appropriate to obtain cooperation from my child. I understand that cooperation is necessary when performing dental procedures to allow for the safest possible setting and the best possible treatment outcome. I give my written and implied consent to use the following procedures when necessary:

Lil Pearls
Pediatric Dentistry

Tell-show-Do
Tell-show-do is a technique used with children to explain what is expected at each visit. We tell them what will be done, show them how it will be done, and then do what we have explained to them. Praise is used to reinforce the child's cooperative behavior.

Voice control
Voice control is a method used for a child who is capable of understanding, but is not listening to requests. The attention of a child is gained by changing the tone or increasing the volume of the dentist's voice without getting angry with the child. Praise is used to support the child's attention to the dentist.

Restraint
Active: Active restraint by parent or dental personnel protects the child from injury during a dental procedure. The parent, dentist, or assistant helps hold a child's head, arms, or legs to prevent harmful movements during treatment.
Passive: Passive restraint with a safety blanket (papoose) is sometimes used to prevent injury to an uncooperative child and to enable the dentist to provide the necessary treatment.

Nitrous oxide
Nitrous oxide (laughing gas) is administered to the anxious child through a small breathing mask, which is placed over the child's nose. This allows the child to relax during the procedure, but does not put the child to sleep. After the mask is removed, the effects of the gas wear off in approximately 5 minutes through breathing with 100% oxygen.

Sedation/General anesthesia
If we are unable to gain your child's cooperation with the following procedures, the doctors of Lil Pearls Pediatric Dentistry may recommend treatment under sedatives or general anesthesia. This is a separate appointment and will be discussed further if and when it is recommended for your child.

I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

I confirm that I am the parent or legal guardian to the child receiving treatment. I hereby state that I have read and understand all of the above information and give my written and implied consent for my child to be treated by Lil Pearls Pediatric Dentistry.

_____ _____
Signature of parent, legal guardian, or personal representative Date

_____ _____
Please print name of parent, legal guardian, or personal representative Relationship to patient

_____
Patient name

NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

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

OUR LEGAL DUTY
We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 1, 2015, and will remain in effect until we replace it.

We may change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We may 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. We will post a copy of our notice in our office and on our website (www.lilpearlsdental.com). The effective date of the Notice is provided above.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact the Privacy Officer whose contact information is provided at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We may use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to another dentist or healthcare provider providing treatment to you, or if we refer you to another health care provider.
Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may need to share part of your health information with our billing department, your insurance company, collection agencies or attorneys assisting us with collections, and others who are responsible for your bills, such as your spouse, as necessary for us to collect payment. For example, we may give information about a dental procedure that you had to your dental insurance company so it will pay us or reimburse you for your dental procedure.
Healthcare Operations: We may use and disclose your 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, and licensing or credentialing activities.
To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.
To Other Persons Involved in Your Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your 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 disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.
Use and Disclosure of Health Information Required by Law: We may use and disclose your health information when required by federal or state law; when required in court or administrative proceedings; for public health activities; to health oversight agencies; to coroners, medical examiners, and funeral directors; to the military; to federal officials for lawful intelligence and national security activities; to correctional institutions regarding inmates; to law enforcement officials; to

report abuse, neglect, or domestic violence; to avert a serious threat to your health or safety or the health and safety of others; and as authorized by state worker's compensation laws.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Contacting You: We may use and disclose your health information to contact you about appointments and other matters, and to send you electronic billing statements. We may contact you by telephone, text, email, or mail. We may leave you messages at the telephone number you give us.

Health-Related Services: We may use and disclose your health information to send you information by mail or email about our health-related products and services available to you, general dental health news and information, and offers available only to our patients. We will tell you how to cancel these communications.

Your Authorization: As explained in this Notice, we may use and disclose your health information for treatment, payment, or health care operations. In certain situations, whether you agree or object, as required by law, we may be obligated to send your health-related information, but we cannot use or disclose your health information for any other reason without your written authorization. You may give us written authorization to use your 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 uses or disclosures already made with your authorization while it was in effect.

PATIENT RIGHTS

Right to See and Copy Your Health Information: You have the right to see or get copies of your health information, with limited exceptions. If we deny your request due to one of these exceptions, we will respond to you in writing with the reason we cannot grant your request, and describe any rights you may have to request a review of our denial. You must make a written request us to access your health information. Your written request must be signed and dated. We may charge you a fee for expenses such as copies, staff time, and postage. Instead of providing you with a copy of your health information, we may prepare a summary or an explanation of your health information for a fee, if you agree in advance to the form and fee of the summary or explanation.

Right to Accounting of Disclosures of Your Health Information: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, and healthcare operations, and certain other activities for the last 6 years. If you request this accounting more than once in a 12-month period, we may charge you a fee for responding to these additional requests. You must submit a written request that is signed and dated. Your request must be submitted to the Privacy Officer, 94-11 65th Road, Suite 1B, Rego Park, NY 11374.

Right to Request Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information, including uses or disclosures for treatment, payment, and health care operations, and to family members, friends, or others involved in your care or payment for your care. You must submit a written request that is signed and dated to the Privacy Officer, 94-11 65th Road, Suite 1B, Rego Park, NY 11374. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in certain situations, such as to provide you with emergency treatment).

Right to Request Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. For example, you can ask that we only contact you at work, or only by mail. You must make your request in writing and your request must be signed and dated. Your request must specify the ways in which you wish to be contacted. You do not need to tell us the reason for your request. Your request must be submitted to the 94-11 65th Road, Suite 1B, Rego Park, NY 11374.

Right to Request Amendment: You have the right to request that we amend your health information. You must submit a written request that is signed and dated. Your request must explain why your health information should be amended. Your request must be submitted to the Privacy Officer, 94-11 65th Road, Suite 1B, Rego Park, NY 11374. If we deny your request, we will respond to you in writing with the reason we cannot grant your request and explain your options.

Right to Written Notice: If you receive this Notice on our website or by email, you are entitled to receive this Notice in written form.

INCIDENTAL DISCLOSURES

The Open Bay. We use an open bay in our office for most dental treatment. This type of environment is used for many reasons including positive behavior reinforcement (kids seeing other kids behaving well). Parts of dental treatment and/or conversations may be overheard by other patients or parents in the office. If you find that your child needs additional

privacy, please request a private treatment room. Be aware that scheduling for that room may be limited as we have only two private treatment rooms in the office.

Appointment Reminder. As a general practice, we call our patient's requested telephone number and may leave a message reminding them of their upcoming appointments. This is usually done several days before each dental appointment. Please let us know if you do not want us to contact you in this manner.

Postcards and Letters. From time to time, we may send postcards or letters informing patients of record about new events or changes in our office. Please contact our office if you do not want us to send you postcards or letters.

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 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 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 also may submit a written complaint to the U.S. Department of Health and Human Services.

We support your right to the privacy of your 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.

PRIVACY OFFICER

Should you wish to contact the Privacy Officer, you may do so at the address and telephone number below.

Privacy Officer – Jeffrey Fong, DDS
94-11 65th Road, Suite 1B
Rego Park, NY 11374
Telephone: (347) 682-5688
Fax: (347) 682-5641
Email: info@lilpearlsdental.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received Lil Pearls Pediatric Dentistry's Notice of Privacy Practices. Specifically, I understand that my protected health information will be used to:

- Conduct, plan and direct my or my child's treatment and follow-up among other healthcare providers, who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers (e.g. insurance companies, collection agencies, check processing companies)
- Conduct normal healthcare operations such as quality assessment and physician certifications

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

_____

Patient name

_____ _____

Signature of parent, legal guardian, or personal representative Date

_____ _____

Please print name of parent, legal guardian, or personal representative Relationship to patient

OFFICE USE:

Reviewed by: _____ Date: _____

OFFICE POLICIES

Appointments:

If you are unable to keep your child's appointment, we would appreciate at least 48 hours notice, if at all possible. This will help us utilize that time for another patient who requires an appointment. We would be glad to reschedule your appointment at a more convenient time, if necessary. We reserve the right to charge for missed appointments.

We value your time and we will make every effort to stay on schedule. To do so, it is ideal to arrive 5 minutes before your child's reserved appointment. We reserve the right to reschedule late patients or dismiss habitually late patients from the practice.

Emergencies:

Unfortunately dental emergencies do arise. We will make every effort to assess your child's emergency on the phone and make him/her an appropriate appointment. Based on our experience and the type of emergency we can determine how urgently we need to see your child. We prefer to see emergencies in the earlier part of the day when the office tends to be quieter. We also ask for your patience when we might be delayed in seeing your child due to an urgent situation with another patient.

Financial Policy:

Payment is due at the time services are rendered; the parent who accompanies the patient to the appointment will be responsible for payments. We cannot send statements to others/other parents. If you are unable to be with your child at the time of his/her appointment, payment arrangements should be made prior to the dental visit.

It is our pleasure to process your dental insurance, however, anything denied by the dental insurance is the patient's responsibility. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of fees for treatment and at no time guarantee what your insurance will or will not do with each claim. For out-of-network patients or patients without dental insurance, we require payment in full on day of service.

Please discuss any questions or concerns with us. We are happy to help.

Payment methods:
We accept American Express, Discover, Master Card, Visa, and Cash.
*All returned checks are subject to a twenty-five dollars service charge

Credit Card Authorization:

□ I do not authorize any credit cards to be on file.

□ I hereby authorize Lil Pearls Pediatric Dentistry to keep my credit card on file, in which it could be used to charge any visits my child has, as well as to clear any balances on my account.

We will mail you a statement with a copy of your credit card receipt.

Cardholder's Name: _____
Card type: AMEX □ - DISCOVER □ - MC □ - VISA □
Card Number: _____
Expiration Date: _____
Billing Zip Code: _____
Cardholder's Signature: _____
Date: _____

Photos:

We understand the desire to take pictures of your child's visit for memories and are happy to comply. We only ask that you inform us first, so that the staff does not appear in any recordings/pictures without their consent. It is also important for us to ensure the protection of the privacy of other patients in the office. In addition, we ask that you do not record or take pictures during the procedures.

ACKNOWLEDGMENT that I have read the above policies and agree to the content.

_____ _____

Signature Date

Print name: