Pomerance
INTEGRATIVE DENTAL CARE

Sheryl Pomerance, D.D.S., F.A.G.D.
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Patient's Name _____ Birth date _____ Today's Date _____
___Male ____Female ___Home Birth ____Hospital Birth ____Vaginal birth ____C-Section Birth

Medical problems ___heart disease ___bleeding disorders ___ other _____Birth weight _____ Present weight _____

1. Are you presently breastfeeding ___Yes ___No
If no, how long since you stopped breastfeeding
_____
2. Are you presently using a nipple shield? ___Yes ___No
3. Are you choosing not to breastfeed? ___Yes ___ No__?
4. Are you pumping breast milk ___Yes ___No
5. Are you supplementing using a bottle ___Yes ___No?
6. Are you using a SNS device ___Yes __No?
7. Do you or any immediate family members have any bleeding disorders? ____Yes ____No

Medical History as your child experienced any of the following problems or treatment?
1. Infants are usually given vitamin K at birth to prevent bleeding in the first 8 weeks of life. Did you sign any wavier to refuse the administration of vitamin K? _____Yes _____No.
2. Was your infant premature? ____Yes ____ No
3. Does your infant have any heart disease ___Yes ____ No
4. Has your infant had any surgery? ___Yes ____ No
5. Is your child taking any medications ___Yes ___ No
____Reflux meds ____Thrush meds ___ other _____
Name of medications
_____

Mother's symptoms
_____ Creased, Cracked or blanching of nipples
_____ Painful latching of infant onto the breast
_____ Gumming or chewing of the nipples
_____ Bleeding, cracked or cut nipples
_____ Infant unable to achieve a successful, tight latch
_____ Poor or incomplete breast drainage
_____ Infected nipples or breasts
_____ Abraded nipples
_____ Plugged Ducts
_____ Mastitis
_____ Nipple Thrush
_____ Feelings of depression
_____ Over supply of breast milk
_____ Under supply

Infant's Symptoms
_____Difficulty in achieving a good latch
_____Falls to sleep while attempting to nurse
_____Slides off the breast when attempting to latch
_____ Reflux (Clicking, swallowing air during nursing)
_____Poor weight gain
_____Short sleep episodes (feeding every 1-2 hours)
_____ Apnea- snoring, heavy noisy breathing
_____Unable to keep a pacifier in the infant's mouth
_____Waking up congested in the morning
_____ Only sleeping when held upright position, in car seat
_____ Gagging when attempting to introduce solid foods
_____ Milk leaking out sides of mouth during feedings
_____Waking up congested nap time

Pediatrician _____ Phone number_____
Address _____ City _____State _____ZIP_____
Physicians email address _____
Has your physician evaluated your infant's lip and tongue ties? ____yes _____no_____
Lactation Consultant _____ Phone number_____
_____State _____zip_____ Email Address _____

Referred to our office by _____
Did use the internet to find my office ____ Yes ____ No
Have you visited my web site? _____ Yes ____ No
Additional comments

_____

_____

If you do not understand or speak English, language assistance, free of charge, is available to you..
Our office complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, disability or sex

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Financial Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment.

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is the patient's responsibility to provide the correct insurance information at each visit. As a courtesy to you, we will file your dental insurance via electronic claims.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services. Any balance is your responsibility whether or not your insurance company pays any portion.

FULL PAYMENT is due at the time of service. If insurance benefits apply, **ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES** are due at the time of service.

We accept the following forms of payment: **Cash, Check, Visa, Discover, MasterCard, AmEx.**

Pre-payment with Cash or check discount: We offer a 5% accounting courtesy for all services that are paid in full ***at the time of scheduling the appointment.***

We have also made arrangements with the Care Credit Company to provide payment plans. This allows you to complete your dental work without delay and make relatively small monthly payments. Applications are available and approval can be determined within ten minutes. For your convenience you can also apply online at www.carecredit.com

I have read, understand, and agree to the terms and conditions of this Financial Agreement.

Signature:_____ ***Date:***_____

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

Existing Michigan law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for your disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse/neglect investigation.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement

Please sign this form below to acknowledge that you have today received a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

_____ _____

Patient Signature Patient Name (please print)

I am also signing for my minor children: _____

(please print names)

Date: _____

Patient Consent

Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

_____ _____

Patient Signature Patient Name (please print)

I am also signing for my minor children: _____

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, caregiver)

_____

(please print names)

_____

Date: _____

For office use only

Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

_____

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

_____ _____

Office Personnel (signature) Office Personnel (print name)

Date: _____

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Dear Patients,

Our no-show/cancelation policy is as follows:

A cancelation or a no-show is documented in the event that the patient cancels or no-shows **without giving us two business days notice of their scheduled appointment.** Our office no-show cancelation fee is seventy five ($75.00) per hour.

We truly value our patient's time, just as we hope you value ours. Having said that, whenever a patient does not appear for a scheduled appointment, everyone is affected. You do not get the treatment needed and another patient loses out on the time that was allowed for you.

Please make every effort to provide to at least two business days notice if an appointment must be missed. We understand unexpected conflicts can occurs and that your lives are as busy as ours. We strive to work together with you to fit your schedule.

Thank you in advance for your understanding and cooperation,

Sheryl Pomerance, DDS & Staff

Agreed to and Acknowledged by:

Patient Name: _____

Patient Signature: _____

Date: _____