



Pomerance

INTEGRATIVE DENTAL CARE

Sheryl Pomerance, D.D.S., F.A.G.D.
 154 S. Industrial Drive
 Saline, Michigan 48176
 Telephone: (734) 429-7460
 Fax: (734) 429-5752
www.PomeranceDentalCare.com

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 _____

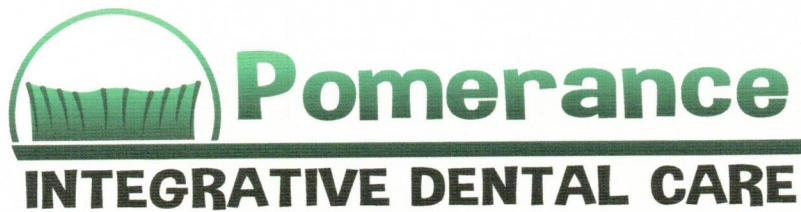
Did use the internet to find my office _____ Yes _____ No

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



Sheryl Pomerance, D.D.S., F.A.G.D.
154 S. Industrial Drive
Saline, Michigan 48176
Telephone: (734) 429-7460
Fax: (734) 429-5752
www.PomeranceDentalCare.com

Dear Patients,

Our no-show/cancellation policy is as follows:

A cancellation 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 cancellation fee is one hundred (\$100.00) 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 occur 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:

A/O 12-13-2022

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.

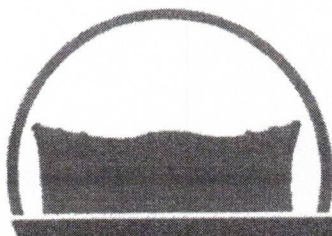
The following circumstances prohibited the patient from signing the Acknowledgement:

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

Office Personnel (signature)

Office Personnel (print name)

Date: _____



Pomerance

INTEGRATIVE DENTAL CARE

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: _____