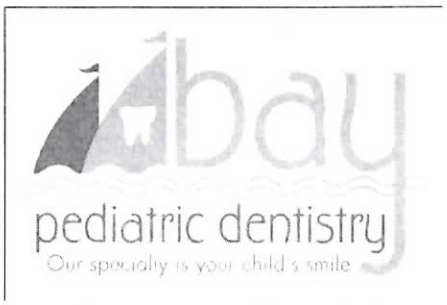


Diana Kyrkos, DDS
Bay Pediatric Dentistry
660 Dover Center Rd
Bay Village, OH 44140
440-892-5556

WELCOME _____

Thank you for scheduling your child at our office. We welcome you to our dental family. Your appointment is scheduled for _____.
Please arrive 10 minutes prior to your appointment time so we can get your chart and paperwork ready.

We will make every effort to work within your schedule when you are scheduling your child for future appointments. Please remember that most of our patients are of school age making it very difficult to give everyone "after school" appointments. Our patients 5 and under are scheduled in the morning, leaving afternoon appointments available for our older patients. We do appreciate at least 48-hour notice of cancellation, so that we may fill your time slot with a child waiting for an appointment.

Please complete the enclosed forms and bring them with you to your child's first appointment.

Thank you again for your confidence in us. We look forward to meeting you and your child and building a long lasting relationship.

Sincerely,
Diana Kyrkos, DDS and
The Team at Bay Pediatric Dentistry

Dear Bay Pediatric Families,

This letter is to advise you of our new billing procedure. First, we would like to thank all of our families who settle their accounts on a timely basis.

Families without insurance are expected to settle their account when services are rendered. If you have a question concerning fees, please ask prior to your appointment. MasterCard, Visa and Discover are available for your convenience.

For families with insurance: As a courtesy, Bay Pediatric will file a claim with your insurance company. Please provide our office with any insurance cards or changes prior to your appointment. Once your insurance company has submitted payment to our office, any deductible and co-insurance must be settled within the first billing period. It is the policyholder's responsibility to follow up with their insurance company when claims have been denied or overdue.

Monthly Billing:

**We will be charging interest to any account with over a 30 day balance.*

*Payment plans can be arranged for any family experiencing financial difficulties.

*Monthly credit card payments can be made via telephone or returned with statements. Please submit cardholder's name, expiration date and billing zip code.

*Any account with a 90 day balance will be forwarded to First Federal Credit Control, Inc.

*All accounts must be paid in full prior to your next cleaning or scheduled visit.

If you have any questions concerning our new billing procedures, please call our office @ 440-892-5556.

Bay Pediatric Dentistry, Inc.
Dr. Diana Kyrkos

660 Dover Center, Suite 17 • Bay Village, OH 44140
Telephone (440) 892-5556 • Fax (440) 899-0408

Parent Information About Behavior Management Techniques for Child Dental Patients

We do our best to give your child the best quality dental care in a safe and caring environment.

Every effort will be made to work with your child to gain cooperation through understanding, gentle guidance, humor, and charm. When these fail there are other management techniques that can be used to eliminate or minimize disruptive behavior. Our dentist(s) and staff have received training in the following techniques accepted by the American Academy of Pediatric Dentistry:

- **Tell-show-do**: the dentist or staff member explains to the child what is to be done, shows an example on a tooth model or on the child's finger, then the procedure is done on the child's tooth.

- **Positive reinforcement**: rewards the child who displays cooperative behavior with complements, praise, a pat on the shoulder, or a small prize

- **Voice control**: the attention of a disruptive child is redirected by a change in the tone and volume of the dentist's voice

- **Mouth props**: a padded device is placed in the mouth to prevent closure of the child's teeth on the dentist's fingers or dental equipment.

- **Hand and/or head holding by dentist or assistant**: an adult keeps the child's body still so the child cannot grab the dentist's hand or sharp dental tools.

- **Nitrous oxide**: medication breathed through a colored/flavored nose mask to relax a nervous child. The child remains awake but is relaxed and calm. Nitrous oxide is also known as *laughing gas*. Children with sensitive stomachs may become nauseated when breathing nitrous oxide.

- **Stabilization wrap**: a body wrap made of fabric mesh and Velcro that is placed around the child to limit movement. It is never used without consent of the parent.

The above behavior management techniques have been explained to me and I have had a chance to ask questions. I understand the what, when, how and why of their use, and the risks/benefits/available alternatives.

_____ _____
parent/guardian date

_____ _____
witness date

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the users and disclosures of my protected health information, and my rights under HIPAA. I understand that your reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry our treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____day of _____, 20_____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Bay Pediatric Laser Dentistry
Diana Kyrkos, D.D.S., Inc.
660 Dover Center Road, Suite 17
Bay Village, Ohio 44140

Bay Pediatric Dentistry, Inc.
Dr. Diana Kyrkos

Consent to Dental Procedures

Patient's Name: _____ Date: _____

Patient's Birth Date: _____

I hereby authorize **Dr. Diana Kyrkos**, Bay Pediatric Dentistry and its employees, agents and assistants to perform all dental procedures or course of procedures necessary to diagnose, treat, and care for the patient's dental needs.

If any unforeseen conditions arise during the course of the procedure, I request and authorize the aforementioned dentist. **Dr. Diana Kyrkos**, and its employees, associates, and assistants to perform or do whatever is clinically necessary to treat such unforeseen condition(s).

I freely give my consent for treatment and all diagnostic dental and clinical procedures deemed necessary to accomplish this treatment. This may include procedures such as dental radiographs, the administration of local anesthetics, analgesia, or the use of behavior management techniques. I understand that the recommendations may change during treatment. I understand that there are no absolute guarantees of the planned procedures or treatment rendered.

_____

Signature of Parent, Patient, or Guardian Date

CHILD'S REGISTRATION AND HISTORY

Date _____

Child's name _____ Male / Female Age _____ Birth date _____

Residence address _____ City _____ State _____ Zip _____

School _____ Address _____ Grade _____

Father's name _____ Mother's name _____

Father's Cell phone _____ Home phone _____ Bus. phone _____

Mother's Cell phone _____ Home phone _____ Bus. phone _____

Email address _____

Person financially responsible _____ Relationship to child _____

Address _____ City _____ State _____ Zip _____ Phone _____

Father's employer _____ Father's Social Security no. _____

Mother's employer _____ Mother's Social Security no. _____

Father's birth date _____ Mother's birth date _____

Primary insurance coverage _____ Who holds insurance _____

Secondary insurance coverage, if any _____ Who holds insurance _____

Whom may we thank for referring you _____

What is child's favorite: sport _____ hobby _____ fictional character _____

DENTAL HISTORY

Date of last visit to a dentist _____

For what service _____

_____

	Yes	No
Has child complained about dental problems _____	☐	☐
Any unhappy dental experiences _____	☐	☐
Any injuries to mouth - teeth - head _____	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc. _____	☐	☐
Any unusual speech habits _____	☐	☐
Any lost teeth _____	☐	☐
Have missing teeth been replaced _____	☐	☐

	Yes	No
Does your child brush teeth daily _____	☐	☐
Do you assist child with tooth brushing _____	☐	☐
How often _____		
Is dental floss used _____	☐	☐
How often _____		
Is fluoride taken in any form _____	☐	☐
Do you desire complete dental service for the child _____	☐	☐

Child's attitude to dentistry _____

Mother's Dental History _____

Father's Dental History _____

You only need to sign & date this form where highlighted

Dental Claim Form

See reverse for instructions

1.	2.	3. Carrier name and address
☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services Provider ID #	☐ Medicaid Claim ☐ EPSDT Prior Authorization # Patient ID #	

PATIENT COVERAGE INFORMATION

4. Patient name (first / m.i. / last)	5. Relationship to employee	6. Sex (m f)	7. Patient birthdate (MM DD YYYY)	8. If full time student (school / city)
	☐ self ☐ child ☐ spouse ☐ other _____			

9. Employee/subscriber name and mailing address	10. Employee/subscriber dental plan I.D. number	11. Employee/subscriber birthdate (MM DD YYYY)	12. Employer (company) name and address	13. Group number

14. Is patient covered by another dental plan (yes no) If yes, complete 15-a. Is patient covered by a medical plan? (yes no)	15-a. Name and address of carrier(s)	15-b. Group no.(s)	16. Name and address of other employer(s)

17-a. Employee/subscriber name (if different from patient's)	17-b. Employee/subscriber dental plan I.D. number	17-c. Employee/subscriber birthdate (MM DD YYYY)	18. Relationship to patient
			☐ self ☐ parent ☐ spouse ☐ other _____

19. **I have reviewed the following treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.**	20. **I hereby authorize payment of the dental benefits otherwise payable to me directly to the below named dental entity.**
›	›
Signed (Patient* – see reverse) Date	Signed (Employee/subscriber) Date

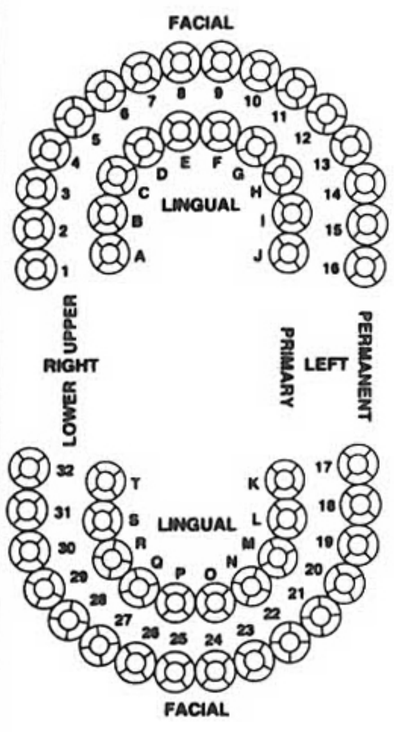
BILLING DENTIST

21. Name of Billing Dentist or Dental Entity	30. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
22. Address where payment should be remitted	31. Is treatment result of auto accident?			
23. City, State, Zip	32. Other accident?			

24. Dentist Soc. Sec. or T.I.N.	25. Dentist license no.	26. Dentist phone no.	33. If prosthesis, is this initial placement?		(If no, reason for replacement)	34. Date of prior placement

27. First visit date current series	28. Place of treatment (Office Hosp. ECF Other)	29. Radiographs or models enclosed?	No	Yes	How many?	35. Is treatment for orthodontics?		If service already commenced enter:	Date appliances placed	Mos. treatment remaining

36. Identify missing teeth with "x"



37. Examination and treatment plan – List in order from tooth no. 1 through tooth no. 32 – Using charting system shown.

Tooth # or letter	Surface	Description of service (including x-rays, prophylaxis, materials used, etc.)	Date service performed Mo.	Day	Year	Procedure number		Fee	

For administrative use only

38. Remarks for unusual services

39. **I hereby certify that the procedures as indicated by date have been completed and that the fees submitted are the actual fees I have charged and intend to collect for those procedures.**	41. **Total Fee Charged**	
› Signed (Treating Dentist) License Number Date	42. **Payment by other plan**	
40. Address where treatment was performed City State Zip	Max. Allowable	
	Deductible	
	Carrier %	
	Carrier pays	
	Patient pays	

HEALTH HISTORY

Child's physician _____ Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No
Is child under care of physician now _____	☐	☐
Is child receiving any medication or drugs _____	☐	☐
Is there any excessive bleeding when cut _____	☐	☐
Has child ever been hospitalized _____	☐	☐
Has child ever had surgery _____	☐	☐
Is there any allergy to penicillin or other drugs _____	☐	☐
Are there other allergies: food - pollen - animals - dust - other	☐	☐

	Yes	No
Does child have good physical coordination _____	☐	☐
Are there any emotional problems _____	☐	☐

HEALTH HISTORY UPDATE

Has child any history of or difficulty with any of the following:

_____ Anemia	_____ Chronic sinus	_____ Hearing	_____ Mastoid	_____ Rheumatic fever
_____ Asthma	_____ Convulsions	_____ Heart	_____ Measles	_____ Thyroid
_____ Bladder	_____ Diabetes	_____ Kidney	_____ Mononucleosis	_____ Tuberculosis
_____ Cerebral Palsy	_____ Epilepsy	_____ Liver	_____ Mumps	_____ Venereal disease
_____ Chicken pox	_____ Fainting	_____ Malignancies	_____ Reflux disorder	_____ Other

Summary: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed.

	Yes	No
May we request release of your child's medical records for our reference _____	☐	☐

This information was discussed with and given by - (print name) _____

Signature _____

Relation to child _____

The following is an item-by-item description of the questions appearing on the new form. All questions in the Billing Dentist Section should be answered as completely as possible to facilitate prompt and accurate reimbursement and to reduce follow-up inquiries. Special completion and mailing instructions, which may vary from company to company, will be printed on the form and will not be addressed here.

1. **Dentist's pretreatment estimate or statement of actual services:** By checking the appropriate box, the form may be processed more quickly and with less chance of error. **Provider identification number:** Some third-party payers use an I.D. number that is different from the T.I.N. or license number.
2. **Medicaid claim, EPSDT, prior authorization number, patient I.D. number:** Include appropriate information for government funded benefit programs as necessary.
3. **Carrier name and address:** The name and address of the carrier where the claim is to be sent. On carrier-supplied claim forms, this information ordinarily will be preprinted at the top of the form.
4. **Patient name:** This should be completed in full for proper identification purposes.
5. **Relationship to employee:** Employee here refers to the insured person and his or her relationship to the patient. This relationship sometimes affects the patient's eligibility, as well as level of benefits available.
6. **Sex:** This is requested for identification purposes and for statistical analysis.
7. **Patient birthdate:** Very important for determination of eligibility.
8. **If full-time student:** Eligibility of the dependent patient may be affected if the patient is over a certain age (specified in the benefits policy) and is still a full-time student.
9. **Employee/subscriber name and address:** Refers to the insured person and is not necessarily the patient.
10. **Employee/subscriber dental plan I.D. number:** If you do not know your dental plan ID # contact your dental plan. Your social security number (SSN) is commonly used for computer and manual processing of claims, but some carriers use an identification number that is different from the SSN.
11. **Employee/subscriber birthday:** Very important for determination of coordination of benefits.
12. **Employer (company) name and address:** Refers to employer of person in #8.
13. **Group number:** Refers to master contract policy number assigned to the employer group.
14. **Is patient covered by another dental plan? or Is patient covered by a medical plan?:** This is to determine multiple coverage. The information contained in items 14-18 is very important in order to determine which other carriers, if any, have primary liability for treatment provided.

15a. **Name and address of carrier(s):** Refers to carrier(s) in #14.

15b. **Group number:** Refers to #14.

16. **Name and address of other employer(s):** Refers to employer offering plan in #14.

17a. **Employee/subscriber name (if different from patient's):** Refers to employee from #16.

17b. **Employee/subscriber dental plan I.D. number:** Refers to Employee in #17a. If you do not know your dental plan ID # contact your dental plan. Your social security number (SSN) is commonly used for computer and manual processing of claims, but some carriers use an identification number that is different from the SSN.

17c. **Employee/subscriber birthdate:** Refers to employee in #17a. Necessary for coordination of benefits.

18. **Relationship to patient:** Refers to employee in 17a.
19. **Patient signature block:** The patient is defined as an individual who has established a professional relationship with a dentist for the delivery of dental health care. For matters relating to communication of information and consent, this term includes the patient's parent, caretaker, guardian, or other individual as appropriate under state law and the circumstances of the case.
20. **Employee/subscriber block:** This block must be completed if the patient and/or the dentist wish to have benefits paid directly to the provider. This is an authorization of payment and does not constitute an assignment of benefits. It does not create a contractual relationship between the dentist and the payer.
21. **Name of Billing Dentist, or Dental Entity:** The individual dentist's name or the name of the group practice/corporation responsible for billing. This may differ from the actual treating dentist's name. This is the name that should appear on any payments or correspondence that will be remitted to the billing dentist.
22. **Address where payment should be remitted:** Self explanatory.
23. **City, state, zip:** Self explanatory.
24. **Dentist's social security number or T.I.N.:** Refers to dentist or dental entity in #21. These numbers are frequently used as individual provider identification numbers. The Internal Revenue Service requires that either the social security or tax payer identification number of the billing dentist or dental entity be supplied only if the provider accepts payment directly from a third-party payer. Report the SS# if the billing dentist is unincorporated. Report the corporation T.I.N. if the billing dentist is incorporated. If the billing entity is a group practice, clinic, etc., the entity's T.I.N. should be entered.
25. **Dentist's license number:** Frequently used as a means of provider identification. This should be the license number of the billing dentist. This may differ from that of the treating dentist, which appears in the Dentist's signature block at the bottom of the form.
26. **Dentist's phone number:** Self explanatory. Include area code also.
27. **First visit date current series:** Important to determine what services are covered when a patient becomes eligible in the middle of an active treatment plan.
28. **Place of treatment:** Depending on where treatment is rendered, medical and/or hospital coverage including dental benefits may be activated. ECF stands for "extended care facility."
29. **Radiographs or models enclosed:** Indicates whether diagnostic materials were submitted. Assists in return of proper number of materials to dentist.
30. **Is treatment result of occupational illness or injury?:** Refers to possible application of Workers Compensation, which would alter coverage available and carrier involved. Important for coordination of benefits and accurate claims processing.
31. **Is treatment result of auto accident?:** Will affect reimbursement in no-fault auto cases. Indicates whether another party's insurance may be responsible. Also important for coordination of benefits.
32. **Other accident?:** Similar to #30 and #31.
33. **If prosthesis, is this initial placement?:** Most dental contracts have specific limitations on replacement of dentures, partials, crowns, and bridges. This is used to determine eligibility and liability.
34. **Date of prior placement?:** Contracts specify time limitations concerning the replacement of prosthetic devices.
35. **Is treatment for orthodontics?:** When orthodontics are covered, dates and months of treatment remaining will affect the prorated monthly reimbursement made to the dentist.
36. **Identify missing teeth with "x":** Self explanatory.
37. **Examination and treatment plan:** Self explanatory. Use the American Dental Association's Current Dental Terminology (CDT-2) for appropriate procedure codes.
38. **Remarks for unusual services:** Use to indicate any information which you feel may be helpful in determining the benefits for the treatment. If space is inadequate, utilize unused portion of #37, or attach a separate sheet.
39. **Dentist's signature block:** The treating dentist's signature and license number.
40. **Address where treatment was performed:** Complete this section if the treatment was performed at a different location than indicated in #22 and #23.
41. **Total fee charged:** Sum of the fees for each procedure reported.
42. **Payment by other plan:** If known, indicate the dollar amount paid by other benefit plan(s).

For administrative use only: Area where carrier calculates benefits.

Payment itemization: The spaces under "payment by other plan" will be completed by the carrier and may vary from carrier to carrier.