Welcome to Fremont Children's Dentistry!

Patient Information

Patient Name: _____ Nickname/Preferred Name:_____ Today's Date:_____
Last First MI

Birth Date:_____ Age: _____ Social Security #: _____ ☐ Boy ☐ Girl

Names and ages of brothers and sisters _____

Responsible Party Information

Father: _____ ☐ Married ☐ Single ☐ Other

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell):_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Information:_____
Name Street City State Zip Code

E-mail address:_____ Primary Language Spoken_____

Mother: _____ ☐ Married ☐ Single ☐ Other

Social Security #: _____Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell):_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Information:_____
Name Street City State Zip Code

E-mail address:_____ Primary Language Spoken_____

Insurance Information

Primary

Insurance Plan Name and Address: _____

_____

Name of subscriber: _____
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary

Insurance Plan Name and Address: _____

_____

Name of subscriber: _____
Last First MI

Subscriber's Birth Date: _____ ID #: _____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office who referred you to our practice: _____

Health Information

Patient Name:_____ Name child goes by:_____
Birth Date:_____ Age:_____ Weight:_____Lbs

1. Has there been any change in your child's general health in the last year?..... ☐ Yes ☐ No
2. Has your child been hospitalized in the last two years? ..... ☐ Yes ☐ No
3. Does your child have a heart condition or heart murmur? ..... ☐ Yes ☐ No
4. Have you been told that your child should have antibiotics before dental visits? ..... ☐ Yes ☐ No
5. Does either your family or your child have a history of complication from general anesthesia? ☐ Yes ☐ No
6. Has your child ever had radiation therapy? ..... ☐ Yes ☐ No
7. Are your child's immunizations up to date? ..... ☐ Yes ☐ No
8. If applicable, is the patient taking birth control medication? ..... ☐ Yes ☐ No
9. Is the patient pregnant? ..... ☐ Yes ☐ No
10. Date of last tetanus vaccination:_____
11. Date of last physical exam:_____ Name of Physician:_____ Phone:_____

*Other than #7, if you marked yes to any of the above, please explain:_____

_____

12. List all of your child's allergies, include adverse reactions to any drugs, medication, latex, foods:

_____

Has your child ever been diagnosed with any of the following? Please check those that apply:

☐ ADD/ADHD	☐ Cleft lip/palate	☐ High blood pressure	☐ Respiratory Problems
☐ AIDS or HIV positive	☐ Diabetes	☐ Injuries to Face/Mouth	☐ Rheumatic Fever
☐ Anemia	☐ Developmental Delay	☐ Intellectually disabled	☐ Seizures
☐ Arthritis	☐ Ear disorders	☐ Jaundice/Liver disease	☐ Sickle Cell anemia
☐ Asthma	☐ Eating disorders	☐ Jaw joint pain	☐ Skin conditions
☐ Autism	☐ Endocrine disorders	☐ Kidney Disease	☐ Speech Delay/Therapy
☐ Behavioral problems	☐ Epilepsy/Seizures	☐ Lung Disease	☐ Stomach Problems
☐ Blood disease	☐ Eye disorders	☐ Organ Transplant	☐ Thyroid problems
☐ Bone/joint problems	☐ Excessive Bleeding	☐ Pacemaker	☐ Tonsils/Adenoids surgery
☐ Cancer/Tumor	☐ Head Injuries	☐ Premature birth	☐ Tuberculosis
☐ Cerebral Palsy	☐ Hemophilia	☐ Psychiatric treatment	☐ Tumors
☐ Chemical Dependency	☐ Hepatitis (any type)	☐ Radiation Treatment	☐ Upper respiratory infection

Please explain the condition further and/or list any other condition your child might have:_____

_____

List any medications your child is currently taking: _____

Dental History information

Is this your child's first visit to the dentist?..... ☐ Yes ☐ No Previous Dentist:_____
Date of last visit:_____ Reason for visit?_____Date of last x-rays:_____
Does the patient use a pacifier or do they suck their thumb? ☐ Yes ☐ No Are they still using a baby bottle?..... ☐ Yes ☐ No
Have they had orthodontic treatment?..... ☐ Yes ☐ No What does your child normally drink?_____
Do they snore when they sleep? ..... ☐ Yes ☐ No Do they have difficulty opening their mouth? ☐ Yes ☐ No
Are they grinding their teeth?..... ☐ Yes ☐ No Any gum problems that you are aware of?..... ☐ Yes ☐ No
Has your child had a toothache recently? ..... ☐ Yes ☐ No If yes, please explain:_____
Does having dental treatment make your child nervous?..... ☐ Yes ☐ No If yes, please explain:_____
Have they ever had a bad experience in the dental office?.... ☐ Yes ☐ No If yes, please explain:_____
Has ever had any complications following dental treatment?. ☐ Yes ☐ No If yes, please explain:_____
How many times a day does the child brush their teeth?_____ By whom?_____
How do they normally do at the dentist?_____ How do think your child will act toward the dentist?_____
Is there any additional information about your child you would like the dentist to know?..... ☐ Yes ☐ No
If yes, please explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any change in my child's health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of parent or legal guardian

For Dentist Use Only

Update and Signature: _____ Date: _____

Update and Signature: _____ Date:_____

Consent for Treatment

As a minor child, it is necessary that signed permission be obtained from the parent or legal guardian before any dental treatment can begin. **It is also necessary for minor patients to be accompanied by an adult of legal age and who can give legal consent for treatment at each appointment**.

It is our intent that all care shall be of the best possible quality for each child. Providing high quality care can be made very difficult, or even impossible, due to the lack of cooperation of some patients. Among the behaviors that can interfere with the provision of quality dental care are: hyperactivity, avoidance movements, refusing to open mouth long enough to perform the necessary dental treatment, and aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or dental instruments.

With the use of warmth, kindness and understanding we will do everything in our power to provide a positive experience for your child when they visit our office; as we treat our patients the way we would like our own children to be treated. To gain the cooperation of young patients and eliminate disruptive behavior and/or prevent patients from causing injury to themselves or others, the Academy of Pediatric Dentistry approves several behavior management techniques. The techniques that we may use while providing dental care for your child may include the following: **(please initial that you have read these items)**

- **MODELING:** The environment that the patient will be in is demonstrated prior to the first appointment. (Initial) _____
- **TELL-SHOW-DO:** The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's fingers. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior. (Initial) _____
- **POSITIVE REINFORCEMENTS:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, or a prize. (Initial) _____
- **MOUTH PROPS:** A special plastic and rubber device is used between the teeth to assist the patient in keeping their mouth open and preventing fatigue of the facial musculature during longer procedures. (Initial) _____
- **SEDATION:** We commonly administer Nitrous Oxide inhalation to accomplish treatment while providing a positive dental experience. During the administration of Nitrous Oxide your child should not lose consciousness and will remain aware of their surroundings. Your child will not receive nitrous oxide without you being further informed and obtaining your consent for such a procedure. We do not offer oral, IV, or other forms of sedation as our doctors believe that the potential risks of these procedures in our facility outweigh the benefits. (Initial) _____
- **PHYSICAL RESTRAINT BY THE DENTIST/DENTAL ASSISTANT OR PARENT AND VOICE CONTROL:** It is not our wish or intention to use restraint in any form. As a matter of fact, we do not have a papoose board in the office. Please do not ask us to perform treatment in this fashion; this is not good for anyone involved, especially your child. Sometimes the attention of a disruptive child can be gained by changing the tone or increasing or decreasing the volume of the voice. The sudden nature of a command can sometimes help a child from losing their self-control. If necessary, we will instruct you, the parent, on how you can help us.

I hereby state that I have read and understand this consent, and that all questions about the procedure(s) have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. I give my consent for the administration of local anesthetics and nitrous oxide (laughing gas). I understand that consent by a legal guardian for extraction of any teeth will be necessary prior to extraction and this will be recorded in the clinical entry the day of treatment. If my child ever has a change in his/her health or his medications change, I will inform the doctor at the next appointment without fail. At no time will care be rendered to a child without informing the parent or guardian of such care. For specific procedures, further information will always be provided. I further understand that this consent will remain in effect until such time that I choose to terminate it by written request.

_____ _____

Signature of parent or legal guardian Date

Fremont Children's Dentistry Office Policies

Parents present in the treatment areas:
Fremont Children's Dentistry does not have a specific policy on parental presence during treatment. We greatly appreciate the trust you have placed in us to treat the most precious member(s) of your family. Research has repeatedly shown that children under the age of four may experience some stranger anxiety and therefore it is best if they are accompanied by a family member. Children who are four or older, however, consistently do better if the parent is not present during treatment. This allows for unobstructed communication between the dental team and the patient. We do not support the concept of having the parent leave the treatment area after the patient exhibits unwanted behavior because the young patient may take this as a punishment. We will treat your child the way we would like our own children to be treated by other health professionals and therefore we will ask for your presence as a "silent" observer if behavior becomes an issue. Please be aware that your presence may not allow us to perform any treatment and we may have to schedule a different appointment. Again, we appreciate your confidence and trust.

No-Show/Failed appointments:
We request that you give us at least a 48 hour notification if you are unable to keep an appointment. Not only is this a general courtesy, but this allows us to schedule other patients who may be waiting to be seen. Repeated failure to show for appointments will not allow us to schedule any more treatment for your child. We understand that circumstances will occur which may keep you from attending an appointment, however, **after the second failed appointment without proper notification, we will assist you in making arrangements to have your <u>family's</u> care transferred to another dental office.**

Late arrivals:
We value your time, therefore we make every effort to stay on schedule. Arriving late to your child's appointment does not allow time for the treatment planned for that appointment. If you arrive later than 10 minutes we will ask you to reschedule on a different date. Sometimes it is better to reschedule than to keep your family waiting. Calling to tell us that you will be late is appreciated but may require the appointment to be rescheduled and will be considered a failed appointment.

Financial Responsibility:
Full Payment is expected at the time of service. Billing you at a later date by our office requires staff time and materials which ultimately result in higher fees. **For this reason, we ask that you take care of the financial portion at each appointment.** Major credit cards, checks and cash are accepted. For patients with dental insurance, the co-insurance, deductible and non-covered expenses are due at the time of service. If you provide us with your insurance information and card, as a courtesy to our patients, we will complete insurance claim forms. The office will file to your insurance company the portion which should be covered by them.

Your signature below signifies that you have read and understand the policies explained in these paragraphs. By signing this form, you accept financial responsibility for this patient, authorize the release of any information necessary to process insurance claims and authorize insurance payments to Fremont Children's Dentistry. You agree to inform the appropriate staff of Fremont Children's Dentistry of any changes in the financial arrangements prior to treatment.

_____ _____ _____

Signature of guarantor of payment/responsible party | Date | Relationship to Patient

Confidentiality Policy

I have read and agree with the notice of Privacy Practices for Fremont Children's Dentistry (HIPPA form).

_____ _____ _____

Signature of parent or legal guardian	Date	Relationship to Patient