Pediatric Dental Associates

WELCOME

Please Tell Us About Your Child

****

Bend (541) 312-2490 Redmond (541) 923-8666
info@pediatricdentistco.com

Tell Us About Your Child

Today's Date _____/_____/____ ☐ Male ☐ Female

Name _____

Nickname _____

Birth Date _____/_____/_____ Age _____

Grade _____ Weight _____

Home Phone _____

Home Address _____

City _____State_____ Zip _____

Names of other children in your family seen by us

_____

Referred By _____

RESPONSIBLE PARTY INFO (Parent or Guardian)

Mother _____

Home Phone _____Cell Phone_____

Home Address _____

City _____State_____ Zip _____

Employer _____

Work Phone _____

Birth Date _____/_____/_____ Age _____

Father _____

Home Phone _____Cell Phone_____

Home Address _____

City _____State_____ Zip _____

Employer _____

Work Phone _____

Birth Date _____/_____/_____ Age _____

Email:_____

Cell Phone # and Carrier:_____

We utilize text and email for appointment reminders.

Emergency Contact

Name _____

Home Phone _____Cell Phone _____

Relationship to Patient _____

PRIMARY INSURANCE

Insurance Co. Name _____

Insurance Co. Phone # _____

Group/ID # _____

Subscriber's Name _____

Subscriber's SS # _____

Subscriber's Employer _____

Relationship to Patient _____

SECONDARY INSURANCE

Insurance Co. Name _____

Insurance Co. Phone # _____

Group/ID # _____

Subscriber's Name _____

Subscriber's SS # _____

Subscriber's Employer _____

Relationship To Patient _____

DENTAL HISTORY

What are your primary dental concerns for your child?

_____

_____

Is this your child's first dental visit? ☐ Yes ☐ No

Is your child taking fluoride? ☐ Yes ☐ No

If yes: ☐ Tablets ☐ Drops

Prescribed By _____

Name of Previous Dentist _____

Date of last dental exam _____

Has your child ever injured their teeth or jaws?
☐ Yes ☐ No If yes when:_____

Does your child have a history of the following:

Nursing/Bottle Habits	☐ Past	☐ Present
Thumb/Finger Sucking	☐ Past	☐ Present
Pacifier	☐ Past	☐ Present
Teeth grinding/Clenching	☐ Past	☐ Present

Has your child ever had an unfavorable medical/dental experience? Please Explain: _____

_____

How do you think your child will act at the dentist office?

_____

_____

Medical History

Who is your child's primary care physician?
Name: _____ Phone: _____

Is your child currently under their care for a medical Problem? ☐ Yes ☐ No If yes please explain: _____

_____

Is your child currently taking any prescription or over-the-counter medications? ☐ Yes ☐ No If yes please explain:

_____

_____

Has your child ever been hospitalized or had surgery?
☐ Yes ☐ No If yes please explain: _____

_____

Is your child allergic/sensitive to latex, acrylics or metals?
☐ Yes ☐ No If yes please explain: _____

_____

_____

Is your child allergic to any medications/foods?
☐ Yes ☐ No If yes please explain: _____

_____

_____

Has your child had any of the following medical problems?

Aids/HIV	☐ Yes	☐ No
Anemia/Sickle Cell	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Asthma (Severity: _____)	☐ Yes	☐ No
Autism	☐ Yes	☐ No
Bladder Condition	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Birth Defects	☐ Yes	☐ No
Bone/Joint Problems	☐ Yes	☐ No
Brain Injury	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No
Cancer, Malignancy, Chemotherapy, or Radiation Please Explain: _____	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No
Child Abuse/Neglect	☐ Yes	☐ No
Chronic Adenoid/Tonsil Issues	☐ Yes	☐ No
Chronic Ear Infections	☐ Yes	☐ No
Cleft Lip/Palate	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Developmentally Delayed	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Epilepsy/Seizures	☐ Yes	☐ No
Fainting/Dizziness	☐ Yes	☐ No
Growth/Development Problems	☐ Yes	☐ No
Heart Surgery/Murmur/Defects	☐ Yes	☐ No
Hearing/Speech Problems	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Hepatitis/Liver Disease	☐ Yes	☐ No
High Blood Pressure	☐ Yes	☐ No
Hyperactivity/ADD	☐ Yes	☐ No
Mental Delay/Disability	☐ Yes	☐ No
Neurological Disorder	☐ Yes	☐ No
Premature Birth	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No

Other: _____

I authorize Pediatric Dental Associates of Bend & Redmond to administer necessary medications and perform such diagnostic, photographic, preventive, therapeutic, and restorative procedures as may be necessary for proper dental health and care. I understand that no treatment will be started until such recommended treatment, time involved, and financial investment has been discussed with me by either one of the Doctors or one of their staff members. The information on this page and the dental/medical history is correct to the best of my knowledge. I grant Pediatric Dental Associates of Bend & Redmond the right to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or other health professionals. I attest that I have answered this dental/medical history to the best of my knowledge and have disclosed my child's complete health history on this document.

Parent/Guardian Signature: _____Today's Date: _____

Privacy Practices 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 (HIPPA). 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 operation of your practice.

I have also been informed of, and given the rights to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and 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 out 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 to prior to this date I revoke this consent is not affected.

Date Signed: _____/_____/_____

Print Patient Name: _____

Signature of Parent/Legal Guardian: _____

Printed Name of Parent/Legal Guardian: _____

Pediatric Dental Associates

Bend (541) 312-2490 Redmond (541) 923-8666

760 NW York Dr Suite #110 Bend, OR 97703 413 NW Larch Avenue Suite #201 Redmond, OR 97756

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Informed Consent for Pediatric Dental Treatment

One of the most important parental policies is to "inform before we perform." Before we begin treating your child, we ask your permission for periodic dental examinations, x-rays, dental cleanings and fluoride applications. We also need your permission to perform dental treatments, restorations, and/or appliances as needed to return all teeth to health and proper function, using local anesthetic and a comfortable mouth prop. The purpose of all of these procedures is to gain and maintain dental health. We expect good results, although no guarantees as to the results may be given.

Although our goal is the best oral health for your child, there are some slight risks involved in getting to that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reaction, swelling and infection. But, ignoring a known dental problem has an even greater risk. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling, considerable risk to the developing adult teeth, and may create future orthodontic and gum problems.

A visit to the dental office presents the young child with lots of new and unfamiliar experiences. It is completely normal for some children to react to these new experiences by crying. All efforts will be made to gain the confidence and cooperation of our young patients by warmth, humor, gentle understanding, and friendly persuasion. High quality dental care for children is our goal. Quality care can be made very difficult or even impossible by the lack of cooperation. Behaviors that can interfere with proper dental treatment are hyperactivity, resistive movements, refusing to open the mouth or keep it open, and even aggressive or physical resistance to treatment.

There are several behavior guidance techniques that are used in our office to help children get the quality dental care they need. Let us tell you about them:

Tell-Show-Do is the use of simple explanations and demonstrations, geared to the child's level of maturity.

Positive Reinforcement is rewarding the helpful child with compliments, praise, and a prize.

Voice Control is getting the attention of a noisy child by using firm commands and varying tones of voice.

Protective Stabilization by Dental Team. With an active child, it is sometimes necessary for the dental team to help hold the head, arms, hands or legs. This is done strictly for *patient safety* and will protect the patient from unnecessary trauma due to movement during the procedure.

Nitrous Oxide (Laughing Gas). The use of nitrous oxide helps to reduce anxiety when delivering necessary dental care. Nitrous oxide calms children, but does not put them to sleep or numb their teeth. It is safe and effective for use in children and lasts only as long as the gas is being given through a nose mask. On rare occasions, the gas can cause an upset stomach and vomiting.

A child who cannot cope with dental treatment using traditional behavior guidance techniques may be a candidate for dental treatment under general anesthesia. If the dentist recommends this, a separate consent form will be reviewed and signed.

THANK YOU FOR TAKING THE TIME TO READ THIS IMPORTANT FORM.

I have read and understand this information on Informed Consent for Pediatric Dental Treatment. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatments in terms that are age appropriate. If any treatment other than the above is needed, it will be discussed with me before beginning such treatment. I understand that I may refuse any or all of the above treatments or procedures. This consent will remain unless withdrawn in writing by the person who has signed on behalf of this minor patient.

PARENT/GUARDIAN SIGNATURE_____**DATE**_____

Pediatric Dental Associates Payment Options

In order to make payment for services as convenient as possible while, at the same time, maintaining operation of our office in the highest standard of comprehensive care, we offer four payment options. We will do our best to give you an accurate estimate of your total fees at the onset of your child's treatment, however, in some cases, the required treatment may be more or less extensive than quoted once treatment begins.

Payment in Full:
Payment in full at the time of service. We accept cash, check, Visa, MasterCard, American Express and debit cards. A 5% courtesy discount will be given with cash or checks. Payment balances over 60 days will accrue a service charge of 18% annually.

Installments:
On approved credit, dental fees may be paid in installments. A down payment is required at the time of service and balance payable in monthly installments. Arrangement for payment of balance with credit or debit card must be made prior to treatment.

Outside Financing:
For smaller monthly payments over an extended period of time, we will be happy to assist you by providing applications for outside financing.

Insurance Assignments:
We will gladly file your insurance claim and accept assignment of benefits. Benefits are estimates only. The actual claim benefits are determined when your insurance carrier receives the claim. The insurance carrier bases their benefits on their "usual and customary" charges and those may not reflect our charges. You are financially responsible at the time of services rendered for any patient portion, co-payments, deductible or non-covered procedures, as determined by your insurance carrier.

Treatment Under General Anesthesia:
Financial arrangements are to be made with financial coordinator at time of consultation.
Hospital/Surgical Center, physician, lab and anesthesiologist fees are not included in our estimate.

CANCELLATION POLICY:
We require 24hrs. Advanced notice to reschedule or cancel appointments. Without advanced notification we reserve the right to charge your account a $50 service charge.

_____ _____/_____/_____

Signature of Parent/Guardian Date

Pediatric Dental Associates

Child's Name: _____

Date of Birth: _____/_____/_____

Permission form for adults other than the parents or legal guardians to bring the child to the office for medical/dental care, and to give consent for medical/dental treatment.

The purpose of this form is to allow you, the parent, the option of naming other adults to bring your child to the office of Pediatric Dental Associates for dental evaluation and treatment. You will be giving permission for these adults to discuss your child's personal medical history with the staff as needed to make medical decisions for your regarding the dental care of your child.

If there are no adults listed, then your child will only be seen when brought by the parent or Legal Guardian.

Date	Parent's Signed Initial	Name of Adult	Relationship to Child	Date & Sign here ONLY when Removing Permission

This form may be modified in writing at any time at the request of either parent.

To remove an adult from this list, simply draw a line through the adult's name, sign your own name and date the time that you make the change in the column to the right.

_____ _____

Print Name of the Parent or Guardian **Relationship to Child**

_____ _____/_____/_____

Signature **Date**

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