Children's Choice
DENTAL CARE

## Patient Information

Name_____ Sex **M** / **F** DOB ___ / ___ / ___ Age_____
First Middle Last

Address_____City_____Zip_____

Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____ Other Phone (_____) _____-_____

Email_____

Thank you for providing your cell # and email. We send important patient communications such as appointment reminders, special offers and events, and patient education newsletters. We will not sell your information to outside parties, nor do we spam!

## Responsible Party

Name_____Relationship_____Marital Status **M** / **D** / **S** / **W**

DOB _____ / ____ / _____ SSN_____ / ____ / _____ Home Phone (_____) _____-_____ Cell Phone (_____) _____-_____

Address_____City_____Zip_____

## Insurance Information

Eligibility is not a guarantee of payment by your insurance for any submitted claims.

Insurance Plan/Company_____Subscriber Name_____

Relationship_____Group Number_____DOB _____ / ____ / _____ SSN_____ / ____ / _____

Subscriber Address_____City_____Zip_____

Employer Name_____Occupation/Job Title_____

Employer Address_____City_____Zip_____Phone (_____) _____-_____

## Medical History

Please answer all following questions as thoroughly and accurately as possible. Circle appropriate response.

1. Is your child under the care of a physician? **Y** / **N**
   If yes, please explain_____
2. Has your child had any serious illnesses or injuries? **Y** / **N**
   If yes, please explain_____
3. Has your child's tonsils or adenoids been removed? **Y** / **N**
4. Is your child current on all vaccines? **Y** / **N**

Has your child had any of the following?

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Abnormal bleeding | **Y** / **N** | Epilepsy | **Y** / **N** | Kidney problems | **Y** / **N** | Rheumatic fever | **Y** / **N** |
| AIDS/HIV | **Y** / **N** | Fainting spells | **Y** / **N** | Liver problems | **Y** / **N** | Scarlet fever | **Y** / **N** |
| Anemia | **Y** / **N** | Growth problems | **Y** / **N** | Lupus | **Y** / **N** | Seizures | **Y** / **N** |
| Asthma | **Y** / **N** | Hearing impairment | **Y** / **N** | Measles | **Y** / **N** | Shortness of breath | **Y** / **N** |
| Blood transfusion | **Y** / **N** | Heart defect | **Y** / **N** | Mitral valve prolapse | **Y** / **N** | Sickle cell anemia | **Y** / **N** |
| Blood pressure | **Y** / **N** | Heart murmur | **Y** / **N** | Mononucleosis | **Y** / **N** | Sinus problems | **Y** / **N** |
| Bone disorders | **Y** / **N** | Hemophilia | **Y** / **N** | Learning disabilities | **Y** / **N** | Thyroid problems | **Y** / **N** |
| Cancer | **Y** / **N** | Hepatitis | **Y** / **N** | Mental disabilities | **Y** / **N** | Tonsillitis | **Y** / **N** |
| Diabetes | **Y** / **N** | Hives | **Y** / **N** | Physical disabilities | **Y** / **N** | Tuberculosis | **Y** / **N** |

Please provide more detail for any of the checked health concerns_____

Does your child have any condition or problem not listed that may impact care or health?_____

Child's Pediatrician Name_____City_____Phone#_____

Please list all medications your child is currently taking_____
Is your child allergic to any of the following:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local anesthetics ☐ Lidocaine/Novacaine ☐ Acrylic metal ☐ Sulfa drugs ☐ Latex

☐ Other allergies or sensitivities _____

## Dental History

1. Is this your child's first dental visit? **Y / N**
   If yes, please explain_____
2. What is your reason for your child's visit today?
3. Has your child experienced any problems with previous dental care or work? **Y / N**
   If yes, please explain_____
4. Is your child nervous or frightened about dental visits? **Our 1st Visit / SOME / Y / N**
5. Have there been injuries to your child's teeth, jaw, or chin? **Y / N**
   If yes, please explain_____
6. Has your child ever been seen by an orthodontist? **Y / N**
   Orthodontist Name_____
7. Does your child brush teeth daily? **Y / N**
8. Does your child floss teeth daily? **Y / N**
9. Does your child have or do any of the following:

| | | | | | |
|---|---|---|---|---|---|
| Clenching | **Y / N** | Nursing bottle habits | **Y / N** | Speech problems | **Y / N** |
| Chewing on objects | **Y / N** | Pacifier sucking | **Y / N** | Teeth grinding | **Y / N** |
| Mouth breathing | **Y / N** | Sleep apnea | **Y / N** | Thumb/finger/lip sucking | **Y / N** |
| Nail biting | **Y / N** | Snoring | **Y / N** | Tongue thrusting | **Y / N** |

## Referral Source

If you were referred to us by a doctor, patient, or employee, please tell us whom to thank_____
How did you hear or learn about our office? Check all that apply.

☐ Advertisement
☐ Building sign
☐ Children's Choice website
☐ Insurance company
☐ Health fair, school or public event Event/School:_____
☐ Other business/health provider Name:_____
☐ Online search listing (ie, Google, Bing, Safari)
☐ Social media (ie, Facebook, Instagram)

## Financial Policy

When benefits are assigned directly to this office, if the insurance company sends you a check in error, you are responsible for immediate and complete reimbursement. If the insurance company has not paid the entire benefit available, you are directly responsible for payment of any outstanding amount. At any point during treatment, if the insurance company becomes uncooperative, we reserve the right to refuse to work with that insurance company and will look to you for payment for any remaining balance, and you will be responsible for settling with your insurance company.

**I assume financial responsibility for the child named on this form. I understand that payment is due on the day services are rendered. I authorize Children's Choice Pediatric Dental Care to collect payment from the insurance company. I understand the insurance company may only pay a portion of my bill, and ultimately, I am responsible for full payment.**

_____ _____
Responsible Party Signature Date

## Acknowledgement

**I certify that the provided information is true and correct to the best of my knowledge. I agree to notify Children's Choice Pediatric Dental Care about any changes in my child's health status or the above information. I acknowledge receipt of this office's Notice of Privacy Policies. Further, I understand that Children's Choice Pediatric Dental Care will release private information ONLY to previously authorized individuals and insurance providers.**

_____ _____
Responsible Party Signature Date

## Receipt Acknowledgement of Dental Materials Fact Sheet

**I acknowledge that I have received and read a copy of the Dental Materials Fact Sheet** (dated 2004) **as required by law.**

_____ _____
Responsible Party Signature Date

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## Informed Consent for Treatment

Informed consent indicates your awareness of and agreement to the various procedures done at Children's Choice Pediatric Dental Care. You understand that you have the right to ask any questions and that we have the obligation to provide you with appropriate answers.

It is our intent to provide the best possible quality care for your child. Providing such care may sometimes be difficult or even impossible because of the lack of cooperation from a child.

All efforts will be made to obtain the cooperation of a child. We will always use warmth, friendliness, persuasion, humor, and kindness. There are several common behavior management techniques used by the dentist to protect the safety of your child, to eliminate disruptive behavior, and to prevent your child from causing injury to themselves or others due to uncontrolled movements. The following are techniques commonly used in our practice to sooth and calm an uncooperative patient:

**Stabilization:** The assistant stabilizes an uncooperative child from movement by holding the child's hands, stabilizing the head, controlling leg movements, and/or the use of a pedi-wrap.

**NOTE:** Your child will NOT be treated with a pedi-wrap unless indicated by the doctor, and only with your additional consent to use a pedi-wrap.

If indicated, initial below to give your consent for the use of a pedi-wrap. Otherwise, do not initial and leave blank if you do not consent to the use of a pedi-wrap.

_____ **I consent to the use of a pedi-wrap for my child as indicated by my child's dentist.**
Initial

**Nitrous Oxide:** Nitrous oxide (also known as "laughing gas" or "nitrous) is a mild inhalation sedative mixed with oxygen that is used to help alleviate mild anxiety and discomfort. It is administered through a mask placed over a child's nose. Please be aware that our standard fee for the use of nitrous oxide is most likely NOT covered by your insurance and will therefore be your financial responsibility.

## Consent Form Acknowledgement

**I hereby acknowledge that I have read and understand the consent form. Any questions that may arisen have been answered and all information has been provided to my satisfaction. I hereby give authorization and consent to utilize the above techniques listed, and I consent to treatment as necessary or desirable to the care of my child first named above, including but not limited to whatever drugs, medicine, performance of operations, and/or conduct of laboratory, x-ray, or other studies that may be used by the attending doctor or qualified designate.**

| Patient Name | Responsible Party Name | Relationship to Patient |
|---|---|---|
| | | |

| Responsible Party Signature | Date |
|---|---|
| | |

The licensing authority for Dentists, Registered Dental Assistants, and Registered Dental Hygienists is the California Department of Consumer Affairs.