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

Child's Name _____ Preferred Name_____ DOB: _____

Child's SSN _____ Text Reminders to # (_____) _____-_____

*If we are unable to reach you at any numbers listed who can we contact: Name:*_____

Relationship: _____ *PH#(_____)* _____-_____

Child's Address _____ City _____ Zip_____

How were you referred to our office, Dr., Friend or family member? _____

Who is accompanying this child today? _____ Relationship to child _____

Do you have legal custody of this child? ☐ Yes ☐ No If no, custody belongs to _____

Mother's Name _____ Email Address _____

Mother's Address ☐ Check if same as child's _____

Mother's Cell# (_____) _____-_____ Home# (_____) _____-_____ Work# (_____) _____-_____

Mother's Social Security # _____ Birthdate_____/_____/_____ Employer _____

Father's Name _____ Email Address _____

Father's Address ☐ Check if same as child's _____

Father's Cell# (_____) _____-_____ Home# (_____)_____-_____ Work# (_____) _____-_____

Father's Social Security # _____ Birthdate _____/_____/_____ Employer _____

Primary Dental Insurance Co. Name_____

Address _____Phone# (_____) _____-_____

Insured ID# _____ Group # _____ Employer _____

Insured's Name _____ Relationship to Pt. _____Birthdate _____/_____/_____

Secondary Dental Insurance Co. Name (if applicable) *(Medicaid and All Kids will always be Secondary to Private Insurance.)*

Address _____Phone# (_____) _____-_____

Insured ID# _____ Group # _____ Employer _____

Insured's Name _____ Relationship to Pt. _____Birthdate _____/_____/_____

We verify your **dental insurance** one week prior to your child's date of service. In the event that coverage is inactive for the date of service, we will try contacting you. If we are not notified of current active insurance the appointment will be cancelled until you have contacted us with the current dental coverage.

Medical History Form

Child's Name_____ Child's Birthdate _____ /_____ /_____

Does child have regular medical exams? ☐ Yes ☐ No Are immunizations up to date? ☐ Yes ☐ No

Is child taking any medications? ☐ Yes ☐ No If yes, please list below:

_____

Child's Physician _____ Ph# (_____) _____-_____

Child's Allergies: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Nickel ☐ Dental Anesthetics ☐ Aspirin ☐ Food Allergies

☐ Other(s): _____

Does child currently have, or has child ever had, any of the following diseases, medical conditions, or procedures?

YES NO Heart Murmur
YES NO Rheumatic Fever
YES NO Artificial Heart Valves
YES NO Congenital Heart Defect
YES NO Challenged
YES NO Surgeries / Operations
YES NO Cancer / Tumors
YES NO Chemotherapy
YES NO Jaw Problems TMJ /TMD
YES NO Hearing Problems
YES NO Sickle Cell or Trait (please specify)

YES NO Tonsillitis
YES NO Asthma/Difficulty Breathing
Circle: Mild / Moderate / Severe
YES NO Respiratory Problems
YES NO Blood Transfusion(s)
YES NO Leukemia / Anemia
YES NO Diabetes / Hypoglycemia
YES NO Hemophilia or Abnormal Bleeding
YES NO Behavioral Issues
YES NO Cleft Lip / Palate
YES NO Birth Defects

YES NO Brain Injury
YES NO Autism
YES NO Liver / Kidney / Organ
YES NO HIV + AIDS Physically
YES NO Tuberculosis (TB)
YES NO Psychiatric Problems
YES NO Hyperactivity
YES NO ADD /ADHD
YES NO Fainting/Seizures/Epilepsy
YES NO Cerebral Palsy
YES NO Down Syndrome

Please List any other medical condition, present or past, including any hospitalizations, recent surgeries, name & phone # of specialist(s):_____

_____

Child's Dental Information

Reason for today's visit: ☐ Cleaning / Exam ☐ Treatment ☐ Emergency ☐ Consultation

☐ Referred by Dr._____

Is your child in pain? ☐ No ☐ Yes If yes, for how long? _____

Does your child require pre-medication with antibiotics for treatment? ☐ Yes ☐ No

Previous Dentist _____ Last Dental Visit ____ /____ /____ Last Dental x-rays____ /____ /_____

Guardian is responsible for the cost of all treatment, including x-rays, that has been done by previous dental office.

# of Times per day child brushes _____ Is child's water fluoridated? ☐ Yes ☐ No ☐ Do not know

Does child do any of the following? ☐ Thumb Sucking, ☐ Tongue thrusting, ☐ Heavy Snoring, ☐ Mouth Breathing,

☐ Lip Sucking/Biting, ☐ Tooth Gringing / Clenching

Parent / Guardian Signature _____ Date _____ /_____ /_____

Staff Signature _____ Date _____ / _____ / _____

Informed Consent

Thank you for choosing ToothBuds at Lagoon Park, LLC as your dental care provider. We will make every effort to ensure that your child has a pleasant dental experience. On your child's initial visit, he/she will see our dental hygienist to have his/her teeth cleaned. Usually by age one, we will begin fluoride treatments. We usually begin dental radiography (x-rays) between the ages of four and five. Bitewings or cavity disclosing X-rays are recommended at least once per year to check for cavities between the back teeth. If a patient has a high incidence of dental decay, we may repeat the X-rays at his/her six-month re-care visit. Once a child reaches the age of six, we generally take a panoramic x-ray of the entire mouth to check the position of permanent teeth and to check for missing teeth or pathology. These radiographs are very important if orthodontics may be needed in the future. This x-ray is usually repeated at three-year intervals. Following the visit with the hygienist, we will go over all findings with you, address any concerns you may have, and make recommendations for future treatment.

We again than you for the privilege of having you as a patient!

By my signature, I acknowledge that the above procedures have been explained to me. I understand the risks and benefits of these procedures and give my consent for the doctors and staff of ToothBuds at Lagoon Park, LLC. to complete the above procedures on my child as necessary.

The following non-guardian individual(s) has/have permission to accompany my child(ren) to appointments.

The person(s) listed may make decisions about treatment at any future visit(s).

Name(s) of person(s) allowed to make decisions about my child(ren)'s treatment:

_____

_____

_____

Any procedure that you do NOT wish to be done on your child, please initial below:

☐ Cleaning ☐ X-Rays ☐ Fluoride

May we leave messages on your voicemail regarding your child's dental care, account status, and/or appointments?

☐ Yes ☐ No

May we send you text messages regarding your child's dental care, account status, and/or appointments?

☐ Yes ☐ No

May we send you email messages regarding your child's dental care, account status, and/or appointments?

☐ Yes ☐ No

Primary Cell Phone# (_____) _____ - _____ Primary Email _____

- ☐ **I AGREE** and hereby grant full permission to ToothBuds at Lagoon Park, LLC to use me or my child(ren)'s first name(s) and photographs in any publications or advertising materials wither printed or electronic.
- ☐ **I DO NOT AGREE** to have mine or my child(ren)'s photograph or information used.

Parent/Guardian Sigature_____ Date _____ / _____ / _____

Staff Signature_____ Date _____ / _____ / _____

Patient HIPAA 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 for 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 complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you 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 out treatment, payment, and healthcare 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 revoked this consent is not affected.

Signature_____ Date _____ / _____ /_____

Patient Name _____ Relationship to Patient_____

Financial Policy We are honored that you have chosen ToothBuds at Lagoon Park, LLC for your child's dental care. We wish to establish a long and pleasant relationship with you and your child. While the filing of insurance claims is a courtesy that we gladly extend to you, all charges are ultimately your responsibility from the date services rendered.

All applicable deductibles, co-pays, and non-covered charges are due at the time services are rendered. We accept cash, check, Debit and Credit Cards. Some services may not be covered by your insurance contract. In the event that a given procedure is not covered, payment for these services is your responsibility. Balances not paid in a timely manner will be turned over to collections. If account is turned over to collections, the responsible party agrees to pay a standard 33.33% fee of the balance to the collection agency.

Office Policy

Please Initial in the boxes after reading each of the following:

☐ **Inactive Insurance**: We verify your **dental insurance** one week prior to your child's date of service. In the event that coverage is inactive for the date of service, we will try contacting you. If we are not notified of current active insurance immediately, the appointment will be cancelled until you have contacted us with the current dental coverage.

☐ **Broken Appointments**: We will call and text prior to the appointment. If we are unable to reach you, your appointment card will serve as confirmation of your appointment and implies your obligation to keep your appointment. That appointment time has been reserved especially for your child. Any appointment cancelled or rescheduled less than 48 hours in advance, will count as a missed appointment. Please be considerate of others and our schedule. After two missed appointments, you will be dismissed from our office and we will no longer be able to treat your child. Exceptions to this policy can be determined on an individual basis according to circumstances, such as, occasionally children's illnesses and other unexpected emergences make it necessary to cancel appointment at the last minute.

☐ **Late Arrivals:** Because we schedule appointments every 30 minutes it is critical to arrive on time. If you arrive more than 10 minutes late you may be asked to reschedule for the next available appointment time. Keep in mind we treat children and although it is our intent to stay on schedule children can sometimes be unpredictable causing us to run behind.

Behavior Management Techniques

The following information is provided to allow you to consider the risks, benefits and options, in order that you may make an informed decision about your child's dental treatment. Please read this form carefully and ask about anything you do not understand.

We treat our patients the same way we would want our own family members treated. However, some patients exhibit behaviors that make it difficult or impossible to provide high quality dental care. In this instance, you as the guardian and we as the dental professionals must come to an agreement about how to handle the behavior so that the necessary treatment can be delivered safely.

Among the behaviors that can interfere with quality professional dental care are: hyperactivity, resistive movements, refusing to open mouth or keep it open, and even aggressive or physical resistance to treatment, including, but not limited to, kicking, screaming or grabbing the dentist's hands or instruments.

Our goal is to help our patients master the dental experience. Some patients may cry as part of this learning process. Crying can be a natural release of anxiety and/or an avoidance technique. All efforts will be made to obtain the cooperation of our patients by use of warmth, friendliness, persuasion, distraction, humor, gentleness, kindness and understanding.

In the event that these efforts fail, there are several recognized management techniques that are used by pediatric dentists to gain cooperation, and to prevent patients from causing injury to themselves. We combine the following recognized techniques individually for each patient. If you have any question regarding these techniques ask to speak to a staff member.

Please initial each box below:

- ☐ **Tell, Show, Do**: The patient is told what is to be done, and then shown what is to be done on a dental model, finger, or other object. Then the procedure is done exactly as told. Praise is given to reinforce positive behavior.
- ☐ **Positive Reinforcement**: This technique rewards cooperative behavior. Rewards include praise, compliments, a pat on the back, or a prize, etc.
- ☐ **Mouth Rest**: A device placed in the patient's mouth to prevent accidental closing and/or injury. It allows the jaw muscles to relax for ease of swallowing.
- ☐ **Stabilization by Parent and/or Dentist/Staff**: For reassurance and to prevent the patient from making sudden unsafe movements we will sometimes have a staff member or parent hold the child's hands and/or upper body.
- ☐ **Papoose Board:** A personal protective device used to limit sudden, unsafe movements of the arms and legs and to prevent injury while the dentist provides the necessary treatment.
- ☐ If any further behavior technique is necessary the doctor will consult with you regarding other options.

Child's Name _____

Responsible Party Signature_____ Date _____ / _____ / _____

Staff Signature _____ Date _____ / _____ / _____