Children's Choice
PEDIATRIC DENTAL CARE

PATIENT INFORMATION

Name _____ Sex: M / F
First Middle Last

D.O.B. _____ / _____ / _____ Age _____

Address _____ City _____ Zip _____

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

*E-Mail _____

***Provide your Cell Phone Number and Email to Receive Appointment Reminders, Event dates like our Patient Appreciation Party and Candy Buy Back, Discount Coupons, Surveys and much More!**

RESPONSIBLE PARTY

Name _____ Relationship _____ Marital Status: M / D / S / W

D.O.B. ____/____/____ SSN ____/____/_____ **Home** Phone (____) _____ - _____ Cell Phone (____) _____-_____

Address _____ City _____ Zip _____

INSURANCE INFORMATION

****Eligibility information is NOT a guarantee of payment by your insurance for any claims****

Name of Insurance Company _____ Subscriber's Name _____

Relationship _____ Group # _____ D.O.B. _____ / _____ / _____ **SSN** _____ / ____ / _____

Subscriber's Address _____ City _____ Zip _____

Name of Employer _____ Occupation _____

Employment Address _____ City _____ Zip _____ Phone # (_____) _____-_____

MEDICAL HISTORY

Please answer the following questions as thoroughly as possible and check the appropriate responses!

Describe your child's overall physical health: Excellent / Good / Fair / Bad
1. Is your child currently under the care of a physician or therapist? Y / N
   If so, please describe _____
2. Has your child had any serious illness or injury? Y / N
   If so, please describe _____
3. Have your child's tonsils or adenoids been removed? Y / N
4. Is your child current on all vaccines? Y / N
5. Has your child ever had any of the following?

Abnormal Bleeding	Y / N	Learning Disabilities	Y / N	Measles	Y / N	Tuberculosis	Y / N
AIDS/HIV	Y / N	Mental Disabilities	Y / N	Mitral Valve Prolapse	Y / N	Sinus Problems	Y / N
Anemia	Y / N	Physical Disabilities	Y / N	Mononucleosis	Y / N	Shortness of Breath	Y / N
Asthma	Y / N	Heart Murmur	Y / N	Scarlet Fever	Y / N	Fainting Spells	Y / N
Blood Transfusion	Y / N	Hemophilia	Y / N	Seizures	Y / N	Thyroid Problems	Y / N
Blood Pressure	Y / N	Hepatitis	Y / N	Sickle Cell Anemia	Y / N	Bone Disorders	Y / N

Diabetes	Y / N	Kidney Problems	Y / N	Tonsillitis	Y / N	Growth Problems	Y / N
Epilepsy	Y / N	Lupus	Y / N	Rheumatic Fever	Y / N	Heart Defect	Y / N
Hives	Y / N	Liver Problems	Y / N	Hearing Impairment	Y / N	Cancer	Y / N

Please discuss any of the above problems in more detail _____
Does your child have any disease, condition or problem not listed above that you think we should know about?
_____
Name of child's pediatrician _____ City _____ Phone # (____) _____-_____
Please list **ALL medications** your child is currently taking _____
Please list **ALL allergies** your child has, including medication _____

DENTAL HISTORY

Please answer the following questions as thoroughly as possible and check the appropriate responses!

1. Is this your child's first dental visit? Y / N
2. What is your reason for bringing the child to the dentist today? _____
3. Has your child experienced any problems with previous dental work? Y / N
   If so, please explain _____
4. Is your child nervous or frightened about dental visits? Yes / Somewhat / No / This is our 1st Visit
5. Have there been any injuries to your child's teeth, jaws or chin? Y / N
   If so, please explain _____
6. Has your child ever been seen by an orthodontist? Y / N
   If so, who _____ When _____ Where _____
7. Does your child brush his/her teeth daily? Y / N
8. Does your child floss his/her teeth daily? Y / N
9. Does your child have any of the following?

Sleep Apnea	Y / N	Clenching	Y / N	Speech Problems	Y / N
Thumb/Finger/Lip Sucking	Y / N	Chewing on Objects	Y / N	Mouth-breathing	Y / N
Nursing Bottle Habits	Y / N	Tongue Thrust	Y / N	Grinding	Y / N
Snoring	Y / N	Pacifier Sucking	Y / N	Nail Biting	Y / N

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

_____

CANCELLATION POLICY

We make every effort to accommodate the busy schedules of our patients and their families. If you are unable to attend your appointment for any reason, we require that you notify our office **AT LEAST 24 HOURS** in advance. If you do not notify us 24 hours in advance, you will be charged a **$25** fee.

(Initials) _____ (I understand and agree to the policy above)

FINANCIAL POLICY

I assume financial responsibility for the above named child. **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 that the insurance company may pay only a portion of my bill and that ultimately I am responsible for the full payment. When benefits are assigned directly to this office, if the insurance company sends a check to you in error, we will hold you responsible for immediate and complete reimbursement. If the insurance company has not paid the entire benefit available, we will hold you directly responsible for payment of the 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 of the remaining balance and you will have to settle with your insurance company.

_____ _____
Responsible Party Signature Date

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

_____ _____

Responsible Party Signature Date

PATIENT RECEIPT OF DENTAL MATERIALS FACT SHEET

I acknowledge that I have received & read a copy of the *Dental Materials Fact Sheet* dated May 2004, as required by law.

_____ _____ _____

Responsible Party Name 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 attempt to use warmth, friendliness, persuasion, humor and kindness. There are several other common behavior management techniques that are used by the dentist to protect the safety of your child, to eliminate disruptive behavior and to prevent the child from causing injury to themselves or others due to uncontrolled movements. The following are the 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, and/or controlling leg movements or the use of a pedi-wrap. (**NOTE**: Your child will not be treated with a pedi-wrap at this time.) Only if indicated by the doctor and with your additional consent to use a pedi-wrap will we treat your child under such conditions.

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

_____

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

I hereby acknowledge that I have read and understand the consent form. Any questions that may have 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 conduct of laboratory, x-ray or other studies that may be used by the attending doctor or qualified designate.

_____ _____

Patient's Name Responsible Party Name

_____ _____ _____

Relationship to Patient Responsible Party Signature Date

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