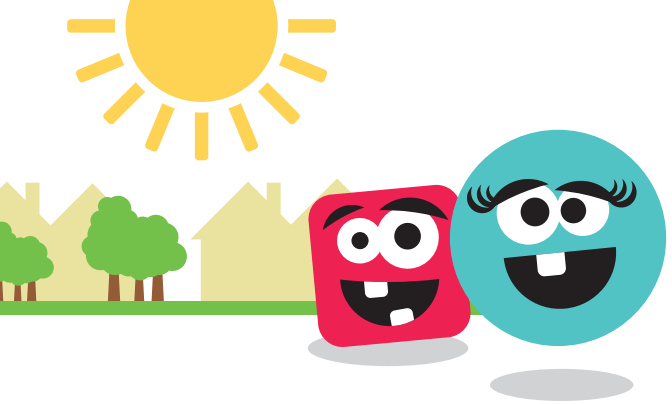
Registration Form



LITTLE HOUSE OF SMILES
Children's Dentistry

Child Information

Name: ☐ Male ☐ Female

Phone:

Address:

Birthdate: Age:

Dental Insurance Information

Insurance Company Name:

Subscriber's ID Number:

General Information

Today's Date:

Your Name:

Relation:

Do you have legal custody of this child? ☐ Y ☐ N

Previous/Present Dentist:

Last Visit Date:

Dentist's Phone:

Emergency Contact (not living with you):

Name:

Phone:

How did you hear about us?

☐ Website ☐ Yelp ☐ Insurance

☐ Other

☐ Father ☐ Step-Father ☐ Guardian	☐ Mother ☐ Step-Mother ☐ Guardian
Name:	Name:
Phone (if different):	Phone (if different):
Email:	Email:
Address (if different):	Address (if different):
Social Security #: Date Of Birth:	Social Security #: Date Of Birth:
Drivers Licence#:	Drivers Licence#:
Employer:	Employer:
Phone:	Phone:
Address:	Address:
Name of Person Responsible for Account:	Parents Marital Status: ☐ Married ☐ Partnered ☐ Separated ☐ Single ☐ Widowed/Divorced

Dental History

Why did you bring the child to the dentist today?

Has the child ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin.) If so, when? ☐Y ☐N

Is the child currently in pain? ☐Y ☐N

Does the child require antibiotics before dental treatment? ☐Y ☐N

Has the child ever had a serious/difficult problem associated with previous dental work'? ☐Y ☐N

Is the child's water fluoridated'? ☐Y ☐N

Is the child taking fluoridated supplements? ☐Y ☐N

Has the child ever had any pain/tenderness in his/her jawjoint (TMJ/TD)'? ☐Y ☐N

Does the child brush his/her teeth daily? ☐Y ☐N

Floss his/her teeth daily? ☐Y ☐N

Child's Physician:

Phone:

Date of Last Visit:

Is the child currently under the care of a physician? ☐Y ☐N

Please described the child's current physical health:
☐Good ☐Fair ☐Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

Aside from items listed, please list all drugs/that the child is allergic to:
☐Latex ☐Metals/Nickel ☐Plastic ☐Other:

Medical History

Has the child experienced the following medical problems?

☐Y ☐N Abnormal Bleeding/Hemophilia
☐Y ☐N ADD/ADHD
☐Y ☐N AIDS/HIV+
☐Y ☐N Anemia
☐Y ☐N Any Hospital Stays/Operations?
☐Y ☐N Artificial Bones/JointsNalves
☐Y ☐N Asthma
☐Y ☐N Autism
☐Y ☐N Cancer
☐Y ☐N Chicken Pox
☐Y ☐N Congenital Heart Defect
☐Y ☐N Convulsions
☐Y ☐N Diabetes
☐Y ☐N Epilepsy
☐Y ☐N Exposed to HIV, but Neg.
☐Y ☐N Handicaps/Disabilities
☐Y ☐N Hearing Impairment
☐Y ☐N Heart Murmur
☐Y ☐N Hepatitis
☐Y ☐N High Blood Pressure
☐Y ☐N Hives
☐Y ☐N Kidney Problems
☐Y ☐N Liver Problems
☐Y ☐N Low Blood Pressure
☐Y ☐N Lupus
☐Y ☐N Measles
☐Y ☐N Mitral Valve Prolapse
☐Y ☐N Mononucleosis
☐Y ☐N Prosthetics
☐Y ☐N Rheumatic Fever
☐Y ☐N Scarlet Fever
☐Y ☐N Skin Rash
☐Y ☐N Tuberculosis (TB)

Are the child's immunizations current? ☐Y ☐N

Anything you would like to discuss with the Doctor in private? ☐Y ☐N

Please discuss any serious medical problems the child experiences/ed:

Does/did the child experience any of the following?

☐Y ☐N Breast Fed
☐Y ☐N Chewing on Objects
☐Y ☐N Clenching/Grinding Teeth
☐Y ☐N Lip Sucking/Biting
☐Y ☐N Nursing Bottle Habits
☐Y ☐N Speech Problems
☐Y ☐N Thumb/Finger Sucking
☐Y ☐N Tongue/Cheek Biting
☐Y ☐N Mouth Breather
☐Y ☐N Tongue Thrust
☐Y ☐N Nail Biting
☐Y ☐N Used Pacifier

HIPAA Compliant

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian: Date:

Office Use Only

2017-05

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist: Date:

Dentist's Comments:

Pediatric Dentistry Consent

For Dental Examination, Cleaning, Radiographs, Fluoride Treatment, Patient Management Techniques, Restorative Dentistry, and Acknowledgement of Receipt of Information

We recognize the exceptional privilege that we enjoy as specialists in pediatric dentistry. Children are truly delightful and we have a real enjoyment of them in our practice.

Your child's welfare and safety are of utmost importance to us. State Law requires health professionals to provide their prospective patients with information regarding the treatment or procedures they are contemplating. Please read this form carefully and ask about anything you do not understand. We will be pleased to explain it.

It is our intent that all professional care delivered in our dental office shall be of the best possible quality we can provide for each child. Providing high quality care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. All efforts will be made to obtain the cooperation of child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

There are several behavior management techniques that are occasionally used by pediatric dentists to gain and encourage the cooperation of child patients and prevent patients from causing injury to themselves due to potentially harmful movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. Tell-show-do: The dentist or assistant explains to the child what is to be done in simple terms and by repetition and then shows the child that is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
2. Positive reinforcement: We always use this technique which rewards the child who displays any positive behavior. Rewards include compliments, praise, a pat on the back, a hug or a prize.
3. Voice control: The attention of the child is gained by changing the tone or volume of the dentist's voice (caring, warm, but firm).
4. Stabilization: The assistant will always comfort our patient by holding their hands. The dentist or the assistant may need to gently stabilize the child's head and/or control leg movement to prevent any sudden movement.
5. Sedation: Sometimes drugs are used to relax a child who needs it. These drugs may be administered orally. The child does not become unconscious. You will be further informed and your specific consent obtained if we feel there is a need for sedation. If you have reason to believe sedation will be necessary, please let us know.
6. General anesthesia: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. You will be further informed and your specific consent will be sought if we feel there is a need for general anesthesia.

I hereby authorize Dr. Nyasha M Scott and Associates assisted by their dental auxiliaries, to perform upon my child (or legal ward) a dental examination, cleaning, application of topical fluoride, any necessary radiographs (x-rays, motion pictures or diagnostic aids, and any dental work, and to utilize the behavior management techniques listed on the preceding form, in order to assist in the provision of the necessary dental treatment for my child (or legal ward)

Although the occurrence is extremely remote, some risks could be associated with any dental procedure. For example, bleeding, discoloration, nausea, vomiting and allergic reactions associated with such procedures.

I acknowledge that all original records and diagnostic aids are the property of Little House of Smiles, Children's Dentistry. Copies may be furnished upon written request base upon established policies of the office. There will also be a fee for all copies produced. I grant permission to Little House of Smiles, Children's Dentistry to produce, or use at its sole discretion, these records, radiographs, and photographs for the purpose of teaching, research, or scientific publications.

I hereby state that I have read and understand this consent, and that all questions about the procedures described have been answered in satisfactory manner.

Patient's Name: _____

Date of Birth: _____

Parent/Guardian's Name: _____

Signature: _____

Date: _____

Financial Policies and Dental Insurance Conditions

Payment is expected the day service is rendered. This includes co-payments and deductibles. We will gladly accept cash, credit cards, Care Credit and debit cards.

If you carry dental insurance, please present your current insurance card the day of your child's exam. As there are several types of insurance, you should contact your employer or insurance representative to obtain precise information about your coverage.

Please understand that we file insurance as a courtesy. You will be responsible for any charges denied by your insurance plan. If you have any questions about your insurance and the reimbursement schedule, you should contact your insurance directly.

A late charge of 1.5% per monthly billing cycle will be applied to accounts over 60 days old, regardless of insurance involvement.

We charge $50.00 per half hour scheduled for missed appointments, unless a 48-hour notice was received. Please remember, once an appointment has been made this time has been reserved especially for your child.

In instances of repeated non-compliance, we reserve the right to discontinue care. This would be after " Please remember, once an appointment has been made this time has been reserved especially for your child.

I certify that my child is covered under the insurance company presented. I assign all insurance benefits directly to Little House of Smiles, Children's Dentistry. I understand that I am responsible for payment of services rendered and responsible for paying the co-payment and deductible not covered by my insurance. I hereby authorize Little House of Smiles, Children's Dentistry to release all information necessary to secure the payment of the benefits. I authorize the use of this signature on all my insurance submissions whether electronic or manual. The parent/guardian (signed below) agrees to be fully responsible for the total payment of procedures performed in this office. In cases of shared custody and/or divorced/ separated parents, the parent/guardian presenting the child for treatment is responsible for the charges incurred.

Parent/Guardian Signature: _____ Date: _____

Acknowledgment of Dental Materials Fact Sheet

I, _____,
acknowledge I have reviewed a copy of the State Board of California Dental Materials Fact Sheet provided by Little House of Smiles, Children's Dentistry.

Patient Name: _____

Parent/Guardian Signature: _____ Date: _____

Office Use Only
We attempted to obtain written acknowledgment of receipt of our notice of privacy practices, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgment
- ☐ Other (please specify): _____

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