Patient Information Form

Name:_____Nickname:_____Birth Date:_____
Address:_____City: _____ State:_____Zip:_____
Home Phone:_____ Cell Phone:_____
Email (for appointment reminder):_____
Please check here ☐ if you do not want text messaging appointment reminders
Sex: Male or Female Name of school patient attends:_____
Whom may we thank for referring you?:_____

Head of Household (if have dental insurance, list policyholder)

Name of person responsible for this patient:_____
Relationship to patient:_____
Address (if different from above):_____ City: _____ State:_____Zip:_____
Home phone:_____ Cell Phone:_____
Birth Date:_____ Social Security:_____ Marital Status:_____
Email:_____

In my absence, I give permission to:_____to accompany my child and consent for any needed treatment.

Signature of Parent or Legal Guardian: _____ **Date:** _____

Patient History

GENERAL

Does your child have siblings?:_____If so, names & ages:_____
What things does your child enjoy?:_____

DENTAL

Date of last dental visit_____ Previous Dentist_____

Describe the primary concern with your child's teeth:_____
Has your child had any unfavorable reactions to past dental treatment? If so, please explain:
_____

Does/Is your Child:

o Yes o No	Presently in dental pain?	
o Yes o No	Need dental work completed	(referred from another dentist or you feel they do)
o Yes o No	Require antibiotics for dental work?	
o Yes o No	Have any extra, missing, or extracted teeth?	If so, please circle answer
o Yes o No	Gag easily	
o Yes o No	Have a history or present today with trauma to the head, face or teeth?	Which one(s)?
o Yes o No	Use a pacifier, suck thumb/finger/lip, bite lip	If so, please circle answer
o Yes o No	Bite or chew nails	
o Yes o No	Grind teeth/clench Jaws/have TMJ pain?	If so, please circle answer
o Yes o No	Have any other habits not listed above?	If yes, please specify_____

o Yes o No Brush daily If not, how often?_____
o Yes o No Floss daily If not, how often?_____
o Yes o No Breastfed Age discontinued_____
o Yes o No Bottlefed Age discontinued_____
o Yes o No Drink juice or other flavored beverages? If yes, how often? _____
o Yes o No Take Fluoride Supplements?

MEDICAL

Child's Pediatrician:_____ Phone Number _____

O Yes O No Immunizations up to date?

Please check any problems or conditions that may apply to your child & circle exact answer

O Asthma/Respiratory problems	O Brain Injury	O Rheumatic Fever
O Epilepsy/Seizures	O Endocrine	O Speech Delay
O Mental Disorder	O ADD/ADHD	O Heart Murmur
O Bleeding disorder/Anemia	O Gastrointestinal/Kidney	O Transfusion
O Cancer	O Hepatitis/Liver/Infectious Dis	O Tuberculosis
O Cerebral Palsy/CNS problem	O Herpes/Fever Blisters	O Vision Disorder
O Developmental Delay	O Diabetes	O Lung Problems
O Drug/Alcohol Abuse	O Autism	

O Other:_____ O My child is healthy

If you said yes to any of the above, please explain: _____

Current medications & dosages taken:_____
Allergies or adverse reactions to any medications (e.g. penicillin/sulfas)_____
Allergies to any substances (e.g. latex)_____
Previous hospitalizations, surgeries, or serious illnesses, and date_____
Has your child had any abnormal bleeding associated with previous extractions, surgery, or trauma? (If yes, please explain)_____

Is there anything else you would like us to be aware of regarding your child?_____

Authorization and Release:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk and that it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners as necessary.

May we request release of your child's medical and dental records?_____

With your verbal permission, you agree to release your child's records to another doctor at their/your request

Signature of Parent or Legal Guardian: _____ **Date:** _____

Tooth Story Office Policies

Appointments and Cancellations

When we make your appointment, we are reserving this particular time specifically for your child's needs. As a dental practice designed primarily for children, we require adequate time with your child. We ask that you place **all effort** possible in making your child's appointment. If you must cancel an appointment, please give us at least a **48 hour** notice. This courtesy makes it possible to give your reserved time to another patient who needs it. **There is a *$100.00* charge for missed appointments and cancellations less than 24 hours. Each failed and no-show appointment is documented in your child's chart. Repeated cancellations and/or missed appointments will result in loss of future appointment privileges (for example: family scheduling) and/or dismissal from the clinic. Furthermore, we have an obligation to report missed and failed appointments to Kansas Child Protective Services if a child has severe decay and/or is in dental pain. Future appointments will not be scheduled until the missed/no-show fee is paid in full.** We feel that our patient's time is valuable. When your appointment is made, we place all effort in preparing in advance for it. Except for emergency treatment, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

PRIVACY PRACTICES CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the above address to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

FINANCIAL POLICY FOR PRIVATE PATIENTS

We are dedicated to providing our patients with the best treatment available and base our treatment recommendation on what will be best for your child and not what your insurance company does or does not pay for. **As a courtesy, our office will be happy to submit insurance claims for your child. Your dental insurance is a contract between you, your employer, and your insurance company; therefore, you are ultimately responsible for your insurance coverage. Any co-pays, deductibles, or known percentages for your child's dental care must be paid the day services are rendered. However, please remember that in most cases these figures are only estimates. We cannot guarantee what your insurance will pay. You will be responsible for any services not covered or paid by your insurance carrier.** Prior to completing any treatment, we are happy to provide you with a cost estimate indicating our total fee, what we expect your insurance coverage to be, and your estimated out-of-pocket portion. This is only an estimate based upon generalized information provided by your dental insurance. We will be happy to submit a pre-treatment estimate to your insurance company for any treatment. We ask that you contact us immediately after making any changes to your dental coverage, so that we may keep accurate and current records of your account and to expedite reimbursement of your dental benefits. We allow a maximum of 60 days for your insurance company to clear account balances. After 60 days, any unpaid portions will be due in full by you. For your convenience, we accept cash, money orders, credit cards, debit cards and checks (there will be a $30 fee for all returned checks). I acknowledge that I have read, understand, and am willing to comply with the above financial policy.

Signature of Parent or Legal Guardian: _____ **Date:** _____

Tooth Story Parent Guidelines

Our office is very small and mainly designed for the pediatric patient. School-aged children (ages 6 and older) are seen without a parent or guardian in our "open bay" treatment area. Infants, toddlers and preschool children ages 5 and under can be seen with a parent or guardian for their first dental appointment in a specific room just for this purpose. Once a child exhibits age-ready behavior and cooperation, they "graduate" to the open bay area with other children and come back on their own.

For all operative procedures (fillings, extractions, etc.), parents and guardians are asked to wait in the waiting area. For these appointments, it is imperative that Dr. Emilie is able to perform the delicate and skilled work needed efficiently and without distraction. This is done most effectively when the parent does not accompany the child during the procedure. After the treatment is completed, the parent will be invited back and Dr. Emilie will discuss how the treatment went and show the parent the work completed that day.

If you accompany your child to the treatment area, such as new patient exams for patients ages 5 and under, we ask you follow our parent guidelines to help ensure your child has the best possible dental experience.

1. Please allow us to lead your child through the dental experience. We ask that you be supportive of the staff and doctor as they explain and show what we will do during the appointment.

2. Please be a silent observer. We ask that during the appointment you allow the doctor and/or team member to be the main communicator. This is important so we can clearly communicate and start to build a trusting relationship with your child. Children normally listen for their parents' commands first. You may not understand what we are asking at any given moment and mistakenly mislead the child. It is easier for your child to listen to only one command at a time versus several from multiple people.

3. Please refrain from using "scary" words such as "shot", "needle", "drill", "hurt", "pain", "yank" or "pull". We use a friendlier dental language to help create a more positive experience. Our intent is not lie to the child but to use words that help ease common dental anxiety.

4. Please plan to have another adult with additional children in the waiting area. Only patients can come to the treatment area during the appointment time. Siblings or additional children must wait and play in the waiting area with adult supervision. An exception can be made when all children are ages 5 and under, in which the family may be in the new patient exam room together at the same time.

5. If your child is not following directions or is acting out and causing disruption to the other children in the office, we may ask you to return to the waiting area. Many times, when the parent has left, the child's behavior improves and the appointment is finished more smoothly. After the appointment, we will invite you back again and Dr. Emilie will discuss the appointment and the need for any further treatment.

We thank you for your assistance in providing a positive dental experience for your child. Our goal at Tooth Story is to create a fun environment for dentistry and we thank you for your advanced cooperation!

Please sign below that you have read and understand the above statements and that you agree to follow the guidelines.

Signature of Parent or Legal Guardian: _____ **Date:** _____

Tooth Story's Informed Consent

Informed Consent for Patient Management Techniques

Please read carefully and feel free to ask about anything on this form. We will be happy to explain it further.

It is our intent that our dental care delivery be the best quality available. We are highly experienced in helping children overcome anxiety and we ask that you allow your child to accompany us through the dental experience. Dental anxiety is not uncommon in children so please try to not be concerned if your child exhibits some negative behavior; this is normal and will soon lessen with time. Studies and experience have shown that most children react more positively when permitted to experience the dental visit in an environment designed for children.

Every effort will be made to obtain your child's cooperation through warmth, charm, humor, and understanding. When these fail, there are several behavior management techniques our office uses to minimize disruptive behavior. The techniques used are recommended by the American Academy of Pediatric Dentistry and are described below.

- **Tell-Show-Do:** The dentist or assistant first explains to the child what is to be done, then demonstrates on a model or on the child's finger. Finally, the procedure is completed on the patient's tooth. Praise is used to reinforce cooperative behavior.

- **Positive Reinforcement:** This technique rewards the child who displays any desirable behavior. The rewards include compliments, praise, and/or a prize.

- **Voice Control:** The attention of a disruptive child is gained by changing the tone, increasing, or decreasing the volume of the practitioner's voice.

- **Mouth Props:** A rubber device is gently placed in the child's mouth to prevent either intentional or unintentional closure on the dentist's fingers or drill.

- **Touch and Go by dentist/assistant:** A child is held in a way so they cannot grab a moving drill or a sharp object. They are not able to grab the practitioner's hand while delicate work is being performed. This is for the safety of the child and to facilitate treatment.

The above listed pediatric dentistry behavior management techniques have been explained to me. I understand their use, and the risks/benefits/alternatives available. I have had all my questions answered and I realize I can always seek further information or revoke permission for any of these techniques.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Patient Name **Date of Birth**