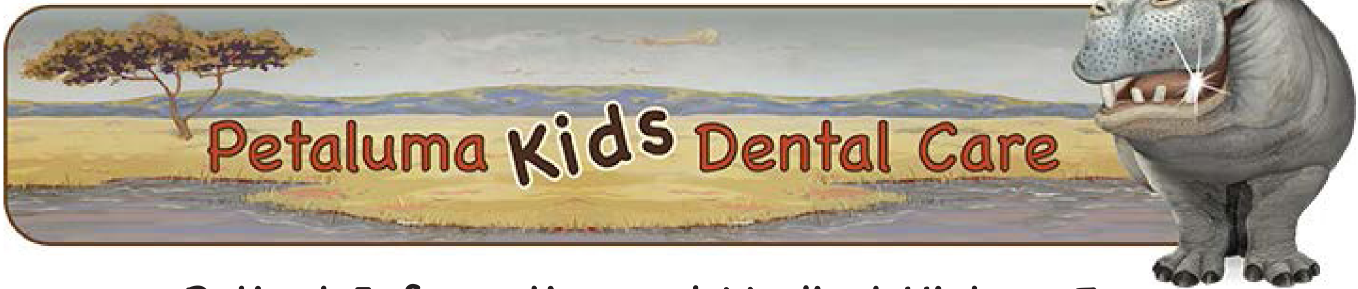


# Patient Information and Medical History Form

Welcome to our office! Please assist us by completing the following questions. Date of Exam

Patient's Name Age Birthdate Gender

Home address City Zip Phone

Cell phone Email address

School Grade

Patient's Previous Dentist (if none, please write 'none')

Does the patient currently see an orthodontist? Yes No If so, who?

Whom may we thank for referring you to our office?

Names and ages of other children in the family

Are there other family members treated by this office Yes No

What are their names?

Marital status of parents Single Married Separated Divorced Remarried Widowed

Parent/Guardian #1 Name

Relationship to Patient Employed by

Phone Number E-mail

Cell Phone

Best way to reach you: Email Phone Text Message

Parent/Guardian #2 Name

Relationship to Patient Employed by

Phone Number E-mail

Cell Phone

Best way to reach you: Email Phone Text Message

Continue -

## Insurance

Primary Insured's Name

Primary Insured's Social Security/ID#

Primary Insured's Date of Birth

Primary Insurance Company

Primary Insurance Group #

Secondary Insured's Name

Secondary Insured's Social Security/ID#

Secondary Insured's Date of Birth

Secondary Insurance Company

Secondary Insurance Group#

## Medical History

Has the patient ever had any of the following? Please mark Yes or No.

| | | |
|---|---|---|
| Asthma<br>Yes No | ADHD<br>Yes No | Allergy to Foods<br>Yes No |
| Allergy to Latex<br>Yes No | Allergy to Local Anesthetic<br>Yes No | Allergy to Medications<br>Yes No |
| Anemia<br>Yes No | Arthritis of any Kind<br>Yes No | Autism Spectrum Disorder<br>Yes No |
| Blood Pressure<br>Yes No | Bone Disorders<br>Yes No | Cancer/Tumors<br>Yes No |
| Chemotherapy/Radiation<br>Yes No | Developmental Delay<br>Yes No | Diabetes<br>Yes No |
| Epilepsy/Seizures<br>Yes No | Fainting/Dizziness<br>Yes No | Frequent Infections<br>Yes No |
| Heart Trouble<br>Yes No | Hearing/Vision Impairment<br>Yes No | Hemophilia/Prolonged Bleeding<br>Yes No |
| Kidney Trouble<br>Yes No | Liver Trouble (Hepatitus)<br>Yes No | Neurologic Disorders<br>Yes No |
| Rheumatic Fever<br>Yes No | Sensory Integration Disorder<br>Yes No | Sickle Cell Anemia<br>Yes No |
| Skin Problems/Sensitivities<br>Yes No | Stomach Problems/Sensitivities<br>Yes No | Thyroid<br>Yes No |

## Dental History

If you checked yes to any of the medical conditions please explain:

Is the patient in good health? Yes No

Pediatrician:

Please list any medications the patient is currently taking:

Is the patient on a special diet? Yes No

Has the patient ever had a head or neck injury? Yes No

Has the patient ever been hospitalized or had a major operation? Yes No

Have there been any injuries to the face, mouth or teeth? Yes No
If Yes, please explain:

Has the patient ever sucked their thumb or finger? Yes No
Until what age?

Is there clicking, popping or discomfort in jaw joints? Yes No

Last dental visit?

Were x-rays taken? Yes No

Primary concern?

Please proceed to the **INFORMED CONSENT AGREEMENT** on the following page.

## Informed Consent

Please check in the allotted spaces to signify that you understand our policies and have thoroughly read through and understand each procedure. Checking provides consent that if the procedure is needed for your child, you understand and consent for the procedure to be performed here at Petaluma Kids Dental Care.

**Missed Appointment/ Late Cancellation Fees**

Yes, I understand

I understand that if I do not provide a 48 hour notice prior to cancelling my child's appointment, or if my child misses an appointment without notifying the office a **$50.00** missed appointment/ late cancellation fee may be assessed.

**Dental Cleanings/ Examinations**

Yes, I understand

I understand that my child will need dental cleanings every 6 months and an examination with Petaluma Kids Dental Care every 6-12 months. I understand that cleanings will consist of prophy fluoride treatment to strengthen the enamel on the teeth. If I chose to not have fluoride, I will let Petaluma Kids Dental Care know. Examinations may include periodic x-rays to check for cavities between the teeth.

**Local Anesthetic**

Yes, I understand

I understand that the doctor may need to inject a local anesthetic to numb the tissue around any tooth requiring treatment. The use of local anesthetic is necessary to control pain and discomfort during a dental procedure. Numbness may last for several hours following treatment and I understand that I must watch my child closely and follow all post-operative instructions to help prevent my child from biting his/her lip or tongue. Other risks associated with local anesthetic include possible allergic reactions, a black and blue mark at the injection site, indefinite numbness or the injected area, or heart palpitations.

**Nitrous Oxide**

Yes, I understand

No, I do not authorize

I authorize the doctor to administer by nose mask nitrous oxide (laughing gas) to my child during his/her dental treatment. Nitrous oxide is used to help my child relax and make him/her feel less anxious. It is possible that my child may experience nausea as a result of nitrous oxide.

**Drugs and Medications**

Yes, I understand

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

**Fillings**

Yes, I understand

I have been advised by Petaluma Kids Dental Care that my child needs a filling. Silver amalgam restoration is an acceptable procedure according to ADA guidelines and, as such, is a treatment used by this office. The advantages and disadvantages of alternative materials will be explained to me.

**Crowns**

Yes, I understand

I have been made aware that my child needs to have a crown placed on one or more teeth. I understand that the doctor prefers to use stainless steel (silver) crowns because of their strength and reliability. As an option, I can request a white crown or ask that a white material be applied to the stainless steel crown (white facing), however, I must discuss this with Petaluma Kids Dental Care to see if my child is a good candidate. Such procedures cannot always be done successfully. If I request a white crown or white facing crown and the doctor agrees, any insurance benefit that my child has may not cover the procedure and I will be responsible for the charges personally. I will have the opportunity to see sample photographs and talk with the dentist.

**Puloptomy (nerve treatment)**

Yes, I understand

I understand that a pulpotomy is necessary when the decay in a tooth reaches the nerve. This procedure will prevent the tooth from becoming infected, or will help cure a tooth that is already infected. Doctors often refer to this procedure as a root canal on baby teeth. The procedure is successful 90% of the time. If the pulpotomy fails, I understand that the doctor may need to extract the tooth and place a space maintainer.

**Extractions**

Yes, I understand

Alternatives to removal of teeth have been explained to me (fillings, crowns, root canals) and I authorize the doctor to remove teeth as indicated in my child's treatment plan. I understand that the tooth removal does not always cure infection, if present, and that additional treatment may be necessary. My child may experience pain, swelling, and bleeding as a result of the extraction(s). I will follow the post-operative instructions provided to me and agree to notify the office immediately if my child's condition does not improve as expected.

**Space Maintainer**

Yes, I understand

I have been informed that a space maintainer may be required when a baby tooth is lost before it is normally ready to fall out. The space maintainer holds the space open so that the permanent tooth will be able to come in properly. If the space maintainer is not placed in the mouth, the teeth could shift causing the permanent teeth to come into the mouth in a crooked manner. While the space maintainer will not guarantee straight teeth, I understand that not using one could result in a more difficult orthodontic problem that could be costly and take a longer time to fix. I agree to have impressions taken of my child's mouth, having a space maintainer made and placed. I will have the opportunity to see samples of them and talk with Petaluma Kids Dental Care.

**Changes In Treatment Plan**

Yes, I understand

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during an examination. I give permission to Petaluma Kids Dental Care to make any/all changes or additions as necessary, after having been informed and in agreement to any and all changes.

**I CERTIFY THAT I HAVE HAD ALL OF MY QUESTIONS ANSWERED AND I FULLY UNDERSTAND PETALUMA KIDS DENTAL CARE'S POLICIES AND THE ABOVE CONSENT TO DENTAL TREATMENT AT THIS OFFICE.**

I hereby request and authorize Petaluma Kids Dental Care and her staff to perform dental work on my child for the purpose of attempting to approve appearance, function, and health of his/her mouth, teeth, bone, and tissue as explained above. The effect and nature of the procedures to be performed, and the risks involved as well as the possible alternative methods of treatment have been fully explained to me.

Parent/Guardian Signature:

Please proceed to the **FINANCIAL POLICY AGREEMENT** on the following page.

# PETALUMA KIDS DENTAL CARE FINANCIAL POLICY AGREEMENT

Thank you for choosing Petaluma Kids Dental Care as your child's dental health care provider. We believe that all patients deserve the very best dental care that we can provide. We also believe that everyone benefits when specific financial arrangements are agreed upon. Please understand that payment of your bill is considered a part of your child's treatment. The following is a statement of our financial policy which we require that you sign prior to any treatment. All patients must complete our information and insurance forms before seeing the doctor.

**FULL PAYMENT IS DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS AND DEBIT CARDS. WE ALSO OFFER CARE CREDIT WHICH IS AN EXTENDED PAYMENT PLAN WITH PRIOR CREDIT APPROVAL.**

As a courtesy to our valued patients, our office will directly bill the insurance company you have provided us. We cannot bill your insurance if you do not provide us with the appropriate and accurate information needed. It is your responsibility to let our office know if there have been any changes to your dental insurance. Your insurance policy is a contract between the insured individual and their employer. The amount of coverage you will receive will depend on the quality of the plan purchased by the employer, not the fee of Petaluma Kids Dental Care. We are not responsible for any limitations in coverage that may be included in your plan. You are responsible for knowing the details of your specific plan. For example, your specific plan may only pay for one fluoride treatment per year and the doctor may recommend it more often. If you only want fluoride treatments one time per year, please let us know.

In the event we obtain a predetermination of dental benefits on your behalf, please be advised that the predetermination is only an estimate provided by us by the insurance provider and is subject to change.
You will be responsible for full payment regardless of whether the amount due for such services is in excess of the predetermination amount. Our office will make every attempt to collect payment from your insurance company. In the rare event that your insurance company does not pay, the parent or guardian will be responsible for the remaining balance in full.

We are an in-network provider with Delta Premier, Delta Dental PPO, Cigna PPO and Aetna PPO insurance companies. Even though we are an in-network provider of these companies, your insurance may only pay a percentage of prevention and/or treatment. The percentage paid is usually determined by how much you or your employer has paid for the coverage or the type of contract your employer has set up with the insurance company. You will be responsible for the uncovered percentage at the time of services rendered. We do not accept any HMO dental plans.

I have thoroughly read, understand and agree to this financial policy.

Parent/Guardian NAME

Parent/Guardian SIGNATURE

Patient NAME Date: