

PATIENT REGISTRATION

ABOUT YOUR CHILD

Child's First/Last Name: _____
Preferred name: _____ Sex: ___ M ___ F
Phone: _____ Birthdate: _____
Child's Home Address: _____
City: _____ State: _____ Zip: _____
How did you hear about us? _____
Siblings seen in our office: _____

Does your child have CHP Plus insurance? No ___ Yes ___
If YES, CHILD's CHP ID#: _____

HOW CAN WE REACH YOU?

Who is responsible for making your child's appointment?

Can we contact you at work if need be? Yes ___ No ___

Do we have your permission to contact you at:

Home ___ Cell ___ Pager ___ E-mail ___

Emergency Contact Name: _____

Relationship: _____

Emergency Contact Phone: _____

PARENT #1 INFORMATION

Mother ___ Father ___ Stepmother ___ Stepfather ___ Guardian ___

Name: _____ Birth date: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____
Pager #: _____ Cell #: _____
E-mail Address: _____
Occupation: _____
Social Security #: _____
Dental Insurance Co. Name: _____
Employer's Name (Company) _____
Insurance Phone #: _____ Policy #: _____

PARENT #2 INFORMATION

Mother ___ Father ___ Stepmother ___ Stepfather ___ Guardian ___

Name: _____ Birth date: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home #: _____ Work #: _____
Pager #: _____ Cell #: _____
E-mail Address: _____
Occupation: _____
Social Security #: _____
Dental Insurance Co. Name: _____
Employer's Name (Company) _____
Insurance Phone #: _____ Policy #: _____

Parents Marital Status:

Single ___ Married ___ Partnered ___ Divorced ___ Separated ___ Widowed ___

RESPONSIBLE PARTY FINANCIAL AUTHORIZATION

The responsible party on your child's account is **the parent who most commonly brings your child(ren) in for their regular dental visits**. This person will receive most of the information from our office regarding preventative care, diagnosis, and proposed treatment and will thus make decisions which best suit your families' dental needs. **This person will also receive mail and phone calls.** Please list the name of the responsible party for your family and sign all of the patient registration sheets as noted. This person is also **financially responsible**.

Responsible Party Name: _____

Relationship to Patient: _____ Birth Date: _____ Sex: ___ M ___ F

Address: _____

City: _____ State: _____ Zip: _____

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**. If my account requires servicing by a collection agency or an attorney, I understand that I will be liable for the collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Tandi V. Donaldson, DDS, MS PC on any unpaid bills for services furnished me or my family. I authorize the release of any dental information necessary to process this claim and all future claims. **The policy in our office is such that the parent or guardian who requests treatment for a child is responsible for all fees for services rendered.**

I give the doctor permission to use such measures as deemed necessary in his professional judgment to render a diagnosis for my child. This would include an oral examination, radiographs (x-rays), prophylaxis, fluoride treatment and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have reported any prior allergic/unusual reactions, abnormal bleeding & other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me should be reported to a dentist.

Signature _____

Date _____

DENTAL / MEDICAL INFORMATION

Patient Name: _____ Date: _____

PROVIDER INFORMATION

Name- Previous Dentist: _____ Phone: _____ Has your child ever had an injury to the teeth, lips, tongue or chin? Yes No
 May we contact previous dentist for records / xrays Yes No Were previous dental experiences positive? Yes No

Pediatrician/Physician: _____ Phone: _____ Address: _____
 Name of any other specialist: _____ Specialty: _____ Phone: _____
 Date of last regular check-up: _____

FLUORIDE & TOOTH BRUSHING

Is your child taking fluoride supplements presently? Y N; If Yes, what form? _____
 How much water does your child drink/day? _____ glasses / day
 Does your child drink: Bottled water Well water City water
 If you have a water filter, what type is it? Carbon Reverse osmosis Other _____
 Does your child use a fluoride toothpaste? Y N; Does s/he swallow the toothpaste? Y N
 Brushing Frequency Inventory: AM PM Both
 What type of toothbrush does your child use? Regular Electric Cloth Other _____
 Dental flossing inventory: Once daily Occasionally Never By parent By child
 Who is responsible for tooth brushing? Parent Child Both

DIETARY FACTS / HABIT ASSESSMENT

Does your child eat between meals? Yes No
 Is your child a good eater? Yes No
 Does s/he eat a balanced diet? Yes No
 Does s/he snore? Yes No
 If not, what are the problem areas? _____
 Please list your child's favorite snacks: _____
Please check if any of the following habits exist or existed:
 Thumbsucking Pacifier
 Grinding Teeth Other Habits: _____
 At what age was bottle / nursing stopped? _____

MEDICAL NARRATIVE

- Is your child:
 - Under the care of a doctor at the present time? No Yes, when? _____ Why? _____
 - Taking any medications at the present time? No Yes, what? _____
 - Allergic to any medications? No Yes, what? _____
 - Allergic to any foods, materials or dyes? No Yes, what? _____
- Has your child:
 - Had general anesthesia? No Yes
 - Had any complications with general anesthesia No Never had general anesthesia Yes, please explain _____
 - Had any surgeries? No Yes, when? _____ Why? _____
 - Ever been a patient at the Emergency room? No Yes, when? _____ Why? _____
 - Ever been hospitalized as a patient? No Yes, when? _____ Why? _____
- Does your child have, ever had or been diagnosed with any of the following: (please check all that apply)

<input type="checkbox"/> HIV+/AIDS	<input type="checkbox"/> Brain Surgery	<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia /Sickle cell trait	<input type="checkbox"/> Cancer-type: _____	<input type="checkbox"/> Heart problem /surgery	<input type="checkbox"/> Polio
<input type="checkbox"/> Allergy / Hay fever	<input type="checkbox"/> Chemotherapy /radiation	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Pregnancy
<input type="checkbox"/> Arthritis / Rheumatism	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Hepatitis A, B or C	<input type="checkbox"/> Reactive Airway Disease
<input type="checkbox"/> Artificial heart valve	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> High/low blood pressure	<input type="checkbox"/> Respiratory problems
<input type="checkbox"/> Artificial joint or limb: _____	<input type="checkbox"/> Cleft Lip /palate	<input type="checkbox"/> Hormonal disturbance	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Convulsions/seizures	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Attention Deficit Disorder / ADHD	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Kidney problems	<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Autism	<input type="checkbox"/> Digestive disturbances	<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sensory Integration Disorder
<input type="checkbox"/> Behavior /Learning Disabilities	<input type="checkbox"/> Down Syndrome	<input type="checkbox"/> Liver problems	<input type="checkbox"/> Shunts
<input type="checkbox"/> Problem learning?	<input type="checkbox"/> Ear aches	<input type="checkbox"/> Malignant hyperthermia	<input type="checkbox"/> VA <input type="checkbox"/> VV <input type="checkbox"/> VP
<input type="checkbox"/> Problem concentrating	<input type="checkbox"/> Emotional disturbances	<input type="checkbox"/> Measles	<input type="checkbox"/> Speech problems
<input type="checkbox"/> Problem cooperating	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Mental retardation	<input type="checkbox"/> Surgeries
<input type="checkbox"/> Problem understanding	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Mumps	<input type="checkbox"/> Syndrome: _____
<input type="checkbox"/> Bleeding disorder	<input type="checkbox"/> Fainting	<input type="checkbox"/> Mouth ulcers	<input type="checkbox"/> Tetanus
<input type="checkbox"/> Birth defects	<input type="checkbox"/> Glandular disturbance	<input type="checkbox"/> Nutritional disturbances	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bone/ Joint/ Orthopedic problems	<input type="checkbox"/> Hearing loss /aids / implants	<input type="checkbox"/> Organ transplant	<input type="checkbox"/> Venereal disease
			<input type="checkbox"/> Whooping cough

Please describe any of the checked items further: _____

- Does your child have any other condition not mentioned above? No Yes, please list _____

I understand the information I have given is correct to the best of my knowledge and will be held in the strictest of confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status.

SIGNED _____ RELATIONSHIP TO CHILD _____ DATE _____

PEDIATRIC DENTISTRY INFORMED CONSENT FOR ANXIETY REDUCING TECHNIQUES

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

ALL IN GOOD INTENTION

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. We believe that any dentist can get your child's work done – our mission is to do so in a manner which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life.

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. In some cases, further anxiety reducing techniques are needed when providing operative care such as fillings, etc. There are several anxiety reducing techniques that are used by pediatric dentists to calm the child, gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. These techniques are **not** a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

Please read this form carefully & ask about anything you do not understand.

Please initial each line to identify that you understand the techniques we use.

PEDIATRIC DENTISTRY ANXIETY REDUCING TECHNIQUES

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 using simple terminology and repetition and then shows the child what 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:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, pat on the back, a hug, or a prize.
- _____ 3. **Voice alteration:** Is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.
- _____ 4. **Mouth props/Rubber dams:** A mouth prop or "tooth pillow" as we call it is used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc) This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a "raincoat" placed on the area of work to be worked on to isolate the teeth and prevent any debris from being swallowed or going to the back of the throat.
- _____ 5. **Immobilization by the dentist:** The dentist controls the child from movement by gently holding the child's hands or upper body, stabilizing the child's head between the dentist's arm and body. This is done for the child's safety.
- _____ 6. **Immobilization by the assistant:** The assistant controls the child from movement by gently holding the child's hands, stabilizing the head, and/or controlling leg movements. This is done for the child's safety.
- _____ 7. **Relaxation Gas:** Nitrous oxide and oxygen (laughing gas) may be administered to relax the child and to raise his/her pain threshold. This allows the child to sit in chair longer / increases their attention span and allows for more work to be done without the child labeling something as painful. **Nitrous oxide and oxygen is not general anesthesia.** The child is not "put to sleep" and does not become unconscious, only relaxed.

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

- 1. The listed pediatric dentistry management techniques have been explained to me.
- 2. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in the pediatric dental community and are merely used only if necessary to provide the best dental care.
- 3. I have been encouraged to ask questions about the anxiety reducing techniques described and they have been answered in a satisfactory manner.
- 4. I hereby acknowledge that I have read and understand this consent.
- 5. I acknowledge that I have not been coerced/ forced to sign this consent and that I have been given the alternative to withdraw from it.
- 6. I hereby authorize and direct Dr. Donaldson and/or Dr. Vuong, assisted by other dentists and/or dental auxiliaries of her/his choice, to utilize, if required, the necessary anxiety reducing techniques to assist in the provision of the required dental treatment for my child (or legal ward).
- 7. I understand that this consent shall remain in effect until terminated by me.

Patient Name

Person Authorized to Consent

Relationship To Patient

Date

INFORMED CONSENT

SUGAR BUGS PEDIATRIC DENTISTRY

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

PATIENT NAME: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Susan Correia
Telephone: 303-427-9779
Address: 7578 Sheridan Blvd. Arvada, CO 80003

Right of Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that the revocation of this Consent will not affect any action we took in reliance on the Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE OF PARENT/GUARDIAN (OR PATIENT IF 18 YEARS OF AGE OR OLDER)

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SIGNATURE: _____ **Date:** _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.