# CHILD New Patient Form

Date: __________________

**These questions are of great value in aiding us to better understand your child.**

The information given will be used in strict confidence to prepare his/her dental chart.

Birth date: ________________

Child's Name: ________________________________________ Nickname, if any: _______________

Name and ages of any brothers or sisters: _________________________________________________

Child's hobbies or interests: ____________________________________________________________

Child's Physician or Pediatrician: ____________________________ Date of last visit: ___________

Family Dentist: _________________________________________________________________________

Whom may we thank for referring you to us: ______________________________________________

Purpose of today's visit (any specific concerns): ________________________________________

___

Does your child have a history of any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Heart problems, murmur or surgery............ | Yes | No | Kidney problems.............................. | Yes | No |
| Rheumatic fever......................................... | Yes | No | Hepatitis or jaundice........................ | Yes | No |
| Diabetes........................ | Yes | No | Liver Problems................................. | Yes | No |
| Cleft lip or Palate............................. | Yes | No | Cerebral palsy or brain damage......... | Yes | No |
| Blood disorders (anemia, etc).................... | Yes | No | Speech or hearing problems.............. | Yes | No |
| Bleeding problems or hemophilia ....... | Yes | No | Emotional or mental problems........ | Yes | No |
| Seizures or epilepsy.............. | Yes | No | Learning or school related problems.. | Yes | No |
| Asthma, tuberculosis or lung problems...... | Yes | No | Other (explain)................................ | Yes | No |

| | Circle One | |
|---|---|---|
| Does your child have a health problem........................................................................ | Yes | No |
| Has your child had any unfavorable (allergic) reaction to drugs, including antibiotics, aspirin, or local anesthetic? If so please specify................................................................ | Yes | No |
| Is your child allergic to foods, pollen, etc? If so, Please specify............................................ | Yes | No |
| Is your child taking medicine? If so, Please specify............................................................ | Yes | No |
| Has your child ever been hospitalized? If so, Please explain........................................ | Yes | No |

| | | |
|---|---|---|
| Has your child ever had surgery? If so, Please explain.................................................. | Yes | No |
| Has your child had any history of thumb sucking, finger sucking, lip biting, or nail biting? If so, Please underline the condition..................................................................... | Yes | No |
| Is your child adopted? (This question is asked so hereditary factors of dental and skeletal growth may be evaluated)................................................................................. | Yes | No |
| Has your child had any unfavorable experiences in a dental or medical office......................... | Yes | No |
| Do you consider your child to be high strung or generally nervous........................................ | Yes | No |
| Do you feel that your child will be an uncooperative dental patient...................................... | Yes | No |
| Has your child had any injuries to the teeth or mouth?........................................................ | Yes | No |

# Child New Patient Form Continued…

Has your child had any toothaches recently?.................................................................Yes No
Is this your child's first visit to the dentist?.................................................................Yes No
If no, date of the last checkup and where: ______________________________

Father's Name: ______________________ Mother's Name: ____________________
Circle one: Single/Married/Divorced/Widowed

Your home address: Street ______________________ City ____________________
State ____________ Zip ___________
Home Phone: _____________ Cell Phone: ____________ Email address: ___________

Father's Occupation: ____________________________________________

Name and address of business: ____________________________ Phone # ________

Mother's Occupation: ____________________________________________

Name and address of business: ____________________________ Phone # ________
Relative's phone number and address: ______________________________
Person responsible for child's account: ______________________________

**CONSENT**

I certify the truth of all information given. I authorize the release of pertinent information to those persons requiring it for the treatment of my child, for the purpose of payment of the account, or credit references. Furthermore, since ____________________ is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental service can be started and accomplished by Dr. Rector and/or legally qualified associates. Such authorization is hereby granted to perform those diagnostic and treatment procedures, including local anesthesia or otherwise manage my child as may be deemed necessary or advisable.

Guardian's Signature: ________________________________ Date: ____________

Witness: ______________________________________ Date: ____________

**THIRD PARTY PAYMENT INFORMATION**

If your account is to be handled by any other method than direct payment to the office, please complete the following section for our records. Your help with this information aids in expediting your dental claim. Check one of the following:

Insurance: ____________ Medicaid: ____________

If Insurance:

Insurer's Name: ____________________________
Address: ____________________________
Social Security or Identification # ________________
Insurance Company: ______________________
Place of employment: ______________________

# Child HIPPA

**Section A:** The Patient

Name: ______________________________________________

Address: ______________________________________________

Phone: (____) _____-_______ Email: ______________________________

**Section B:** Acknowledgement of Receipt of Privacy Practice Notice

I, ______________________________, acknowledge that I have received a Notice of Privacy Practices from the above-named practice.

Parent/Guardian:______________________________________ Date: _____ /_____ /______

If a personal representative signs this authorization on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________

**Section C:** Changes to our office policy:

***There are to be under no circumstances, cell phone usage in operatories.***

We may disclose patient records to another provider by submitting them electronically.

**Family, friends, and other involved in your car or payment for care:** We may disclose your child's medical information to a family member, friend or any other person involved in your child's care or payment of your child's health care. We will disclose only the medical information that is relevant to the person's involvement.

**Signature:**

I attest that the above information is correct.

Parent/Guardian:______________________________________ Date: _____ /_____ /______

Print Name: ______________________________ Relationship: ____________________

# AUTHORIZATION
# TO RELEASE DENTAL NEEDS

Our mission is to be dedicated to protecting the dental health of our patients. We are proud to provide dental care to children and adults of the community. Our office combines the latest dental knowledge and technology together with care and compassion. We want every patient to have a positive dental experience. Our expert staff is great in creating this experience. Your commitment along with our excellent care, will allow for a lifetime of healthy teeth and gums.

______________________________________________________________

Patients Name                                                                 Date of Birth

It is the policy of my office to not release dental patient information about you, unless it is for patient care and treatment or payment. We try to the best of our ability to keep the discussion of patient information to a minimum. If you wish for our dentist and/or office staff to leave messages for you on your home telephone, message number, answering machine, work telephone, voice mail, cell phone, or pager, or to any other person, then you must complete the following:

I authorize The Rector Dental Group or staff to release dental patient information about me by the following methods and agree it is my responsibility for notifying my dentist or office staff whenever I want this to change:

We can call your home or cell number if applicable and leave a message
if no answer........................................................................... Yes ___ No___
We can call you at work.......................................................................... Yes ___ No___
We can communicate with other professional offices and/or insurance
companies concerning patient information.............................................. Yes ___ No___
Are you ok with our open concept practice............................................ Yes ___ No___

Do you give permission to who may be accompanying the child the right to discuss any information pertaining to the above child (i.e.: billing, hygiene, treatment, and any other needs regarding the patient)........................................................................................ Yes___ No___

If no, the parent/guardian will need to bring child to every appointment and will be the only one that we will discuss information with.

______________________________________________________________

Patient Signature / Legal Representative                                 Date

______________________________________________________________

Witness                                                                       Date

# SIGNATURE ON FILE

Patient's Name: ___________________________________________
Last First Middle Initial

I hereby authorize payment of the dental benefits otherwise payable directly to The Rector Dental Group.

___________________________________________
Signature (Insured Person) Date

The Rector Dental Group is authorized to provide pertinent information to those persons requiring it for the use of evaluating and administrating claims for benefits.

I authorize the use of this form on all of my insurance submissions.

I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible for my bill.

___________________________________________
Parent, Legal Guardian or Authorized Person's Signature Date

The Rector Dental Group

# PEDIATRIC DENTISTRY INFORMED CONSENT for PATIENT MANAGEMENT TECHNIQUES and ACKNOWLEDGEMENT of RECEIPT of INFORMATION

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 operatories shall be of the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments.

All efforts will be made to obtain the cooperation of dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. **Tell-show-do**: Dr. Rector or assistant explains to the child what is to be done using simple terminology, 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, and prizes.
3. **Voice control**: The attention of a disruptive child is gained by changing the tone or increasing the volume of Dr. Rector's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.
4. **Mouth props**: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
5. **Physical restraint by the dentist**: Dr. Rector restrains the child from movement by holding down the child's hands or upper body, or stabilizing the child's head between the dentist's arm and body.
6. **Physical restraint by the assistant**: The assistant restrains the child from movement by holding the child's hands, stabilizing the head, and/or controlling the leg movements.

I hereby acknowledge that I have read and understand the consent, and that all questions about the behavior management techniques described have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment. I understand that this consent shall remain in effect until terminated by me.

Patients Name: ______________________________ Date ______________

Signature of Parent or Guardian: ______________________________

Relationship to Patient: ______________________Witness: ______________

Signature of Doctor: ______________________________