

Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1) Child's Information

| | |
|---|------------------------|
| Child's Name: _____ Last First MI | Nickname: _____ |
| Sex: Male <input type="checkbox"/> Female <input type="checkbox"/> | |
| Child's Birthdate: ___/___/___ | |
| Child's Home#: (____) _____ | |
| Child's Home Address: _____ _____ | |
| City | State Zip |

2) Parent #1 Information: Step Parent Guardian Male Female

| | |
|----------------------------|-------------------------------|
| Name: _____ | Birthdate: ___/___/___ |
| Cell#: (____) _____ | |
| Occupation: _____ | SS #: _____ |
| Email: _____ | |

Parent #2 Information: Step Parent Guardian Male Female

| | |
|----------------------------|-------------------------------|
| Name: _____ | Birthdate: ___/___/___ |
| Cell#: (____) _____ | |
| Occupation: _____ | SS #: _____ |
| Email: _____ | |

5) Primary Dental Insurance

| | |
|---|---------------------------------------|
| Insurance Co. Name: _____ | Insurance Co. Phone #: (____) _____ |
| Group # (Plan, Local, or Policy#) _____ | Policy Owner's Name: _____ |
| Relationship to Patient: _____ | Policy Owner's Birthdate: ___/___/___ |
| ID #: _____ | Policy Owner's Employer: _____ |

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of 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

Date

Patient's Name _____ Date of Birth _____

Dental History

Is this your child's first visit to the dentist? **Yes No**

If **No**, who was your child's previous dentist _____

Date of Last visit _____ Date of Last Dental x-rays _____

Any concerns _____

Medical History

Name of Child's Physician _____ Phone _____ Last Visit _____

Medications _____

List all Allergies to (medications, foods, metals/alloys/other substance) _____

Does your child have/had any history of the following:

Please check all that applies

- | | | | |
|--|--|---|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cancer | <input type="checkbox"/> Heart/Heart Murmur | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Ringworm |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic Sinusitis | <input type="checkbox"/> Immunization | <input type="checkbox"/> Sex. Trans. Disease |
| <input type="checkbox"/> Autism/PDD | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Kidney | <input type="checkbox"/> Sickle cell or trait |
| <input type="checkbox"/> Behavioral Problems | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver | <input type="checkbox"/> Thyroid |
| Learning Issues | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Measles/Mumps | <input type="checkbox"/> Tobacco//Drug use |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy (teens) | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Growth Problems | <input type="checkbox"/> Previous Surgeries | <input type="checkbox"/> Other |
| <input type="checkbox"/> Bones/Artificial Joints | <input type="checkbox"/> Hearing | <input type="checkbox"/> Previous Hospitalization | |

For the checked condition, how long? _____

List hospitalization/Surgeries/ER: _____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? **Yes / No**
If YES, explain _____

Does your child need antibiotic prophylaxis prior to dental treatment for SBE Congenital Heart Issues OR other reasons? Yes No

If **Yes**, explain _____

I will not hold my dentist, or any other members of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I authorize the staff Charm Pediatric Dentistry to perform such treatments, services, medications, local anesthesia, analgesia, and accepted behavior management techniques that may be necessary to correct any oral deficiency, abnormality, infection and/or disease. If any conditions are discovered in the course of treatment which, in the opinion of the doctors authorized by this consent, require procedures in addition to or different than those described, I also authorize the performance of these procedures. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained from treatment, I consent to the taking and publication of any photographs in the course of this treatment for the purpose of advancing dental education. I certify that I have read the above consent and questions were answered to my satisfaction.

Patient's/Guardian's Signature _____ Date _____

Dentist's Signature _____ Date _____

DENTAL INSURANCE POLICY

Charm Pediatric Dentistry accepts dental insurance as a courtesy to our patients. Please be informed that your insurance may not cover all procedures at 100%. Most insurances have deductibles, copays, and/or non-covered procedures. **We will do our best** to let you know ahead of time what your copays/deductibles will be for a particular visit. However, **it is the responsibility of the parent/guardian to know their coverages.**

OFFICE POLICIES

Payments: All payments such as non-covered services, deductibles and/or copays are due at time of service. If you have dental insurance, we will submit your claim to your dental insurance. However, your coinsurance is expected at time of service. We accept cash, check & major credit cards.

Leaving the office: It is against the law to treat a child under the age of 18 years of age without the parent or guardian on the premise. Also, treatment plans are subject to change during the course of the procedure and the doctor may need to speak with you. Your availability is of the utmost importance.

No Show Policy: We have a strict “no-show” policy.

You must call us at least **48 hours in advance** if you cannot make your appointment. **Anyone missing 3 appointments will be dismissed from the practice.** All “no-shows” are subject to a charge: **\$50 for missed operatory appointments and \$30 for hygiene appointments. This fee is your responsibility.** The fee will not be covered by your insurance company.

Treatment Appointment Policy: A **child under the age of 18 MUST** come with a patient/legal guardian with court documentation, due to irreversible treatment.

Continuing Care Visits: Exams, cleaning and fluoride treatment are done every 6 months. Please be advised that some insurance covers fluoride only once a year. **Please contact your insurance regarding your coverage.** If you do not want fluoride treatment, please tell the office staff.

X-rays: X-rays are taken yearly or as needed unless you tell us otherwise.

Referrals: Required referrals must be brought in before or on the day of your child’s appointment or the visit will be rescheduled.

Emergencies: True emergencies involve severe pain, swelling or bleeding. We will do our best to accommodate true emergencies.

PATIENT MANAGEMENT TECHNIQUES

It is the intent of our dental care delivery to be the best quality available. Providing high quality dental care to children can be difficult due to a child’s behavior. **Therefore, we ask that you allow your child to come into their appointment room alone. We find one on one communication to be most effective. Please give our policy a chance as it is in the best interest of your child.** Every effort will be made to obtain your child’s cooperation through warmth, charm, humor and understanding. However, when these fails, there are several behavior management techniques used to eliminate or minimize disruptive behavior. These are all routinely used and accepted by the American Academy of Pediatric Dentistry. They are described below.

1. **Tell-show-do:** The dentist or assistant explains to the child what is to be done by demonstrating on a model or on the child’s finger. Then the procedure is done on the patient’s tooth. Praise is used to reinforce cooperative behavior.
2. **Positive reinforcement:** This technique rewards the child who displays any desirable behavior. Rewards include compliments, praise, and a pat on the arm or a prize.
3. **Voice control:** The attention of a disruptive child is gained by changing the tone or increasing the volume of the practitioner’s voice.
4. **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.
5. **Physical restraint by dentist/assistant:** The child is held so that he/she cannot grab a moving drill or a sharp object. This also prevents the child from grabbing the practitioner’s hand while delicate work is being performed. This is for the safety of the child and to facilitate treatment.

The behavior management techniques have been explained to me. I understand their use, and the risks/benefits/alternative 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.

By signing this form, I acknowledge that I understand the terms of the policies and agree to adhere to these policies.

Signature of Parent/Guardian

Date

HIPAA PRIVACY FORM

Charm Pediatric Dentistry
Yoosung Suh, D.M.D.

**ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES**

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of
Privacy Practices.
(Name of parent)

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)
