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: _____ **Nickname**: _____
Last First MI

Male ☐ Female ☐

Child's Birthdate ___/__/___ **Child's Age:** _____

Child's Home#: (_____) _____

Child's Home Address:

_____

_____
City State Zip

2) ☐ Mother's Information: ☐ Step Mother ☐ Guardian

Name: _____ Birthdate:___/___/__

Cell#:(___)_____

Occupation**:** _____ SS #:_____

Email: _____

☐ **Father's Information**: ☐ Step☐her Guardian

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

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

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 **24 hours in advance** if you cannot make your appointment. Anyone missing 3 appointments without giving a 24-hour minimum cancellation notice 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.

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

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.

_____
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)

_____

_____

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