Patient Information

Sandpoint
KIDS DENTISTRY

Patient's Name: ______________ Date of Birth: ________ Age: ______ Gender: ______
Address: ______________ City: ______________ State: ______ Zip: ______
Do we see any siblings? Yes No Their Names: ______________

PARENT/GUARDIAN

Parent's name: ______________ Relationship: ______________ Date of Birth: ______
Employer: ______________ Social Security Number: ______________
Home Phone: ______________ Work: ______________ Mobile Phone: ______________
Email: ______________
Best Contact: O Home Phone O Work Phone O Mobile Phone O E-mail O Text

Parent's name: ______________ Relationship: ______________ Date of Birth: ______
Employer: ______________ Social Security Number: ______________
Home Phone: ______________ Work: ______________ Mobile Phone: ______________
Email: ______________
Best Contact: O Home Phone O Work Phone O Mobile Phone O E-mail O Text

INSURANCE INFORMATION

Primary Dental Insurance
Policy Owner: ______________ Relationship to patient: ______________
Insured SSN: ______________ Date of Birth: ______________ Employer: ______________
Insurance Company: ______________ Phone: ______________
Address: ______________
Group Name: ______________ Policy ID: ______________ Group No: ______________

Secondary Dental Insurance
Policy Owner: ______________ Relationship to patient: ______________
Insured SSN: ______________ Date of Birth: ______________ Employer: ______________
Insurance Company: ______________ Phone: ______________
Address: ______________
Group Name: ______________ Policy ID: ______________ Group No: ______________

I certify that my child is covered by the above Insurance Co and I assign directly to Sandpoint Kids Dentistry all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-pay and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefit. I authorize the use of this signature on all my insurance submission, whether manual or electronic.

______________________________ ______________
Parent/Guardian Signature Date

PEDIATRIC MEDICAL HISTORY

Child's Full Name: ______________________ Date of birth: ______________ Gender: __________

Nickname: ______________ Date of last physical examination: ______________ Height: ________ Weight: ______ lbs

Primary Physician: ____

Medical Specialist: ____

What is your primary concern about your child's oral health? ______________________________

How did you hear about us? ____

Is your child taking any **MEDICATIONS:** prescription, over-the-counter, vitamins, or dietary supplements?

YES NO ____

Has your child ever had a reaction to or a problem with **ANESTHETIC**?

YES NO ____

Has your child ever been hospitalized, had sedation, had surgery or a significant injury, or been treated in an emergency department?

YES NO ____

Has your child ever had a **reaction or ALLERGY** to an **antibiotic**, **sedative** or other **medication**?

YES NO ____

Is your child **ALLERGIC** to **latex** or anything else such as **metals**, **acrylic,** types of **foods** or **dye**?

YES NO ____

How often does your child brush their teeth? ______________________ Does someone help your child brush? YES NO

Has your child been to the dentist before?	YES	NO	Date of last visit ________ Where: ____________
Has your child been sedated for dental treatment?	YES	NO	______________________
Has your child had orthodontic treatment?	YES	NO	______________________
Has your child had a difficult dental appointment?	YES	NO	______________________
Any issues with speech? S, Z, T, D, L, R, Th, Sh?	YES	NO	______________________

How do you expect your child will respond to dental treatment? Very well Fairly well Somewhat poorly Very poorly

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

Inherited dental characteristics	YES	NO	______________
Mouth sores or fever blisters	YES	NO	______________
Cavities/decayed teeth	YES	NO	______________
Injury to teeth, mouth or jaws	YES	NO	______________
Grinding/clinching	YES	NO	______________
Sucking habit after one year of age	YES	NO	______________
Breastfeeding problems	YES	NO	______________

Child's favorite movie? ______________________ Child's favorite color? ______________________

Does your child play any **sports**? YES NO ______________ Does your child need a **mouth guard**? YES NO

Please check all sources of **FLUORIDE** your child receives:

- O Drinking water
- O Toothpaste
- O Over-the-counter rinse
- O Prescription drops/tablets/vitamins
- O Professional in-office treatments
- O Prescription rinse/gel
- O I do **NOT** want my child to receive fluoride varnish

Please circle YES if your child has a history of the following conditions. For each YES, provide details at the bottom.

YES	NO	Prematurity, syndromes, or inherited conditions ___
YES	NO	Problems with physical growth or development ___
YES	NO	Sinusitis, chronic adenoid/tonsil infections ___
YES	NO	Sleep apnea, snoring, mouth breathing ___
YES	NO	Congenital heart defect/disease, heart murmur, rheumatic fever or rheumatic heart disease ___
YES	NO	Irregular heart beat or high blood pressure ___
YES	NO	Asthma, reactive airway disease, wheezing, or breathing problems ___
YES	NO	Cystic fibrosis ___
YES	NO	Frequent colds or coughs, or pneumonia ___
YES	NO	Jaundice, hepatitis, or liver problems ___
YES	NO	Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ___
YES	NO	Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ___
YES	NO	Unintentional weight loss, concerns with weight, or eating disorder ___
YES	NO	Bladder or kidney problems ___
YES	NO	Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems ___
YES	NO	Rash/hives, eczema or skin problems ___
YES	NO	Impaired vision, hearing, or speech ___
YES	NO	Developmental disorders, learning problems/delays, or intellectual disability ___
YES	NO	Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ___
YES	NO	Autism/autism spectrum disorder ___
YES	NO	Recurrent or frequent headaches/migraines, fainting, or dizziness ___
YES	NO	Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) ___
YES	NO	Attention deficit/hyperactivity disorder (ADD/ADHD), MTHFR gene ___
YES	NO	Behavioral, emotional, communication, or psychiatric problems/treatment ___
YES	NO	History of abuse (physical, psychological, emotional, or sexual) or neglect ___
YES	NO	Diabetes, hyperglycemia or hypoglycemia ___
YES	NO	Precocious puberty or hormonal problems ___
YES	NO	Thyroid or pituitary problems ___
YES	NO	Anemia, sickle cell disease/trait, or blood disorder ___
YES	NO	Hemophilia, bleeding disorder, bruising easily, or excessive bleeding ___
YES	NO	Transfusions or receiving blood products ___
YES	NO	Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant ___
YES	NO	Mononucleosis, tuberculosis, scarlet fever, cytomegalovirus, MRSA or HIV/AIDS ___

Is there anything else we should know before treating your child? YES NO

___

___

___

___ Signature of parent/guardian

___ Relationship to child

___ Date

___ Reviewing Dr. Initials

INFORMED CONSENT FOR PEDIATRIC DENTAL PROCEDURES

Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read this form carefully and ask about anything you do not understand. We are more than happy to further explain anything to you.

Local Anesthetics: 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 them from biting or otherwise injuring his/her lip, tongue or cheeks. Other risks associated with local anesthetic include possible allergic reactions, a black and blue bruise at the injection site, indefinite numbness of the injected area, or temporary heart palpitations.

Radiographs (X-rays): I understand that radiographs are required in order to provide the best treatment for my child. I understand the radiation from 4 X-rays is approximately equal to a few hours a day out in the sun. The dentist and staff members make every attempt to limit the radiation exposure to my child.

Fillings: I understand that a more extensive filling than originally diagnosed may be required due to additional decay. Placement of any dental restoration can result in a tooth that is sensitive to hot and/or cold. If these symptoms persist for more than a few weeks, it may be an indication that further treatment is necessary. Due to the fact that teeth are subjected to extreme forces from chewing, grinding and possible trauma it is possible that bonded restorations (white fillings) can fracture or get dislodged resulting in leakage, recurrent decay or infection.

Sealants: I understand sealants act as a barrier protecting the teeth against decay causing bacteria. The sealants are usually applied to the chewing surfaces of the back teeth (premolars and molars) where decay occurs most often. Sealants may periodically come off and may need to be replaced and/or repaired.

Fluoride: I understand that the application of topical fluoride may significantly decrease the number of cavities my child may develop but may not prevent all decay. The effectiveness of fluoride will be influenced by the oral care and diet received at home.

Pulpotomy (nerve treatment): I understand that a pulpotomy or pulpectomy is necessary when the decay in the tooth reaches the nerve. This procedure will help prevent the tooth from becoming infected, or will help a tooth that is already infected. This procedure may be referred to as a root canal on a baby tooth; however, it is less involved and faster than permanent tooth root canal treatment. In a small percentage of cases, the patient's body rejects the nerve treatment, resulting in a failed pulpotomy. If it fails, I understand that the dentist may need to extract the tooth and place a space maintainer. If the pulpotomy is not performed, my child may lose the tooth and the mouth may become swollen and infected.

Nitrous oxide: I authorize the dentist to administer 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 less anxious. It is possible that my child may experience nausea, dizziness and vomiting.

Crowns: I have been informed that my child needs to have a crown on one or more teeth. I understand that the dentist prefers to use stainless steel (silver colored) crowns because of their strength and reliability. Anterior teeth have the option of all white zirconia crowns or stainless steel crowns with white materials applied to the front.

Space maintainer: I have been informed that a space maintainer is needed 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 teeth will be able to come in properly. If the space maintainer is not placed the teeth will shift, causing the permanent teeth to erupt crooked or fail to erupt. While the space maintainer will not guarantee straight teeth, I understand that not using one could result in a more difficult orthodontic problem in that takes longer and is more expensive to treat.
Photos: I authorize and consent to the use of my child's visual image for appropriate purposes, including but not limited to: intra oral photos, extra oral photos

Extraction (removal of tooth): Alternatives to tooth removal have been explained to me (fillings, crowns, root canal treatment) and I authorize the dentist to remove the teeth indicated in my child's treatment plan. I understand that tooth removal does not always cure the infection. I will follow the post-operative instructions provided to me. Bleeding, bruising or swelling may occur.

I understand that dentistry is not an exact science and therefore practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. Additionally, providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Some behaviors will be age-appropriate for the child and some may not. 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.

There are many **behavior management techniques** used by pediatric dentists and approved by the American Academy of Pediatric Dentists to gain the cooperation of child patients to eliminate or reduce disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The most frequently used pediatric behavior management techniques used in this office can be summarized as follows:

TELL-SHOW-DO: The dentist or assistant explains to the child what is to done using simple, age-appropriate words. Secondly, the child is shown on a model, or shown on their finger. Lastly, the procedure is performed for the child as described.
POSITIVE REINFORCEMENT: This technique rewards behavior that is desirable. Desirable behavior is rewarded with compliments, praise, high five or other prize.

VOICE CONTROL: The attention of a disruptive or uncooperative child is gained by changing the tone or increasing the volume of the dentists voice. The content of the conversation is many times less important than the abrupt, sudden or strict nature of the voice tone.
MOUTH PROPS: A rubber prop or similar type of device is placed in the child's mouth to prevent closing and possible injury.
PHYSICAL RESTRAINT BY THE DENTIST, DENTAL ASSISTANT OR PARENT: The dentist or assistant (under direction by the dentist) restrain the child from movement by holding the child's hands, stabilizing the head and/or controlling leg movements.

SEDATION: Various drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperative for dental procedures due to his/her age or maturity. These drugs are administered along with Nitrous Oxide- Oxygen gas. The child does not become unconscious, but your child may fall asleep. There is no guarantee how your child will react to the medication, some children may not experience relaxation but an opposite reaction such as agitation or crying. Your child will not be sedated without a further discussion with you.

The listed pediatric dentistry dental procedures and behavior management techniques have been explained to me. Alternative techniques have been explained to me, as have the advantages and disadvantages of each including the option of rendering no treatment. I hereby authorize and direct Dr. Amanda Caswell-Burt and dental auxiliaries of her choice to utilize the dental procedures and management techniques listed on this consent form to assist in the provision of any necessary dental treatment for my child (or legal ward). I hereby acknowledge that I have read and understand this consent, and that all questions about behavior management techniques described have been answered in a satisfactory manner. I 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 and assume any and all risks associated with the procedures and I understand no guarantees will be made regarding the outcome of treatment. I further understand that this consent shall remain in effect until terminated by me.

I acknowledge my consent for dental treatment.

______________________________	______________________
Patient's Name	Date
______________________________	______________________
Parent/Guardian printed name	Relationship to patient
______________________________	______________________
Parent/Guardian signature	Witness

Sandpoint KIDS DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT **

I ______________________________ have read/received a copy of Sandpoint Kids

(Printed Name)

Dentistry'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

____ Communication barriers prohibited obtaining the acknowledgement

____ An emergency situation prevented us from obtaining acknowledgement

____ Other (Please Specify):

____

Consent for Text/SMS Message Notifications

Our practice offers text messaging for your convenience. Through these messages you have the ability to confirm, cancel, or reschedule appointments as well as make payments or ask questions. If you would like to utilize this feature, please read the consent below and sign.

Consent to Text Messaging for Appointment Reminders and Other Oral Healthcare Communications:

Patients in our practice may be contacted via text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general oral health reminders/information

I consent to receiving appointment reminders and other healthcare communications/information from

Sandpoint Kids Dentistry. I understand that this consent includes authorization for the communication of Protected Health Information via text message.

I understand that this request to receive text messages will apply to all future appointment reminders/ feedback/health information unless I request a change in writing.

I consent to receive text messages from the practice at my listed cell phone numbers.

______ (**Parent/Guardian initials**)

**The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for details).*

This consent applies to:

Child's Name: ____

Child's Name: ____

Child's Name: ____

Child's Name: ____

Child's Name: ____

Child's Name: ____

_________________________ Parent/Guardian Printed Name

_________________________ Parent/Guardian Signature

___________ Date

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