WOODLAKE FAMILY DENTAL

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form to the best of your knowledge, if you have any questions we will be glad to help. We look forward to helping you in maintaining your dental health.

Patient Information

Patient Name:____ DOB: ____________ Sex: M / F

Address : _______________________________ City: ___________________ St: ___ Zip: ________

Home #:_______________ Cell #:_______________ Email: ___________________________

Emergency Contact Name: __________________________ Cell #:__________________________

Who may we thank for referring you?: __________________________

Primary Dental Insurance

Policy Holder:____ DOB: _______________

Relationship to patient: ____________ SSN:_______________ Home #_____________________

Address (if different from patient): ____

Policy Holder Employer: ______________________________ Occupation: __________________

Insurance Co: ____________________________________ Insurance #: _____________________

Group #:_______________ Subscriber ID#_______________

Additional Dental Insurance

Is this patient covered by additional dental insurance? If yes, fill out below.

Policy Holder:____ DOB: _______________

Relationship to patient: ____________ SSN:_______________ Home #_____________________

Policy Holder Employer: ______________________________ Occupation: __________________

Insurance Co: ____________________________________ Insurance #: _____________________

Group #:_______________ Subscriber ID#_______________

Dental History

What would you like us to do today? ____

Are you in any dental discomfort? ____

Former Dentist: ______________________________________ Phone #_____________

Date of last dental visit: __________________________ Date of last x-rays: _____________

How often does your child brush?: ________________ Floss?: _________ Do you assist? : Y / N

How do you feel about the appearance of your child's teeth?: ___________________________

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y/ N If yes, describe: ____

Circle Y/N whether you have had any of the following

Y/N Bad breath
Y/N Periodontal treatments
Y/N Sensitivity to sweets
Y/N Bleeding gums
Y/N Grinding or clenching
Y/N Sensitivity to hot / cold
Y/N Sensitivity on biting
Y/N Clicking or popping jaw
Y/N Broken fillings / Loose teeth
Y/N Sores or growths in mouth
Y/N Food collection between teeth

Medical History

Physicians Name: __________________________ Phone #: _________________________

Date of last visit: _____________________ Are your child's immunizations up to date: Y / N

Is your child currently under physician care? Y/N If yes, describe: ____________________

Has your child ever had any serious illnesses or operations? Y/N If yes, describe:

____

Has your child ever been hospitalized? Y/N If yes, describe: ____________________________

Has your child been to the ER in the last year? Y/N If yes, describe: _______________________

Has your child ever been required to take antibiotics before a dental appointment? Y/N

Has your child ever had a blood transfusion? Y/N If yes, give approx dates: ____________________

Circle Y/N whether your child has had any of the following:

Y/N ADD/ADHA
Y/N AIDS/HIV
Y/N Anaphylaxis reaction
Y/N Anemia
Y/N Anxiety
Y/N Arthritis, rheumatism
Y/N Artificial heart valves
Y/N Artificial joints
Y/N Asthma
Y/N Autism
Y/N Back problems
Y/N Blood disease
Y/N Cancer
Y/N Cerebral palsy
Y/N Chemotherapy
Y/N Circulatory problems
Y/N Cleft palate/lip
Y/N Congenital birth defect
Y/N Congenital heart disease
Y/N Diabetes I or II
Y/N Depression
Y/N Developmental delay
Y/N Down syndrome
Y/N Epilepsy
Y/N Eczema
Y/N Food allergies
Y/N Genetic disorder
Y/N Glaucoma
Y/N Hearing impairment
Y/N Heart murmur
Y/N Heart problems
Y/N Heart surgery
Y/N Hemophilia/abnormal bleeding
Y/N Herpes
Y/N Hepatitis
Y/N High blood pressure
Y/N hydrocephalus
Y/N Immune compromised
Y/N Kidney disease malfunction
Y/N Learning disability
Y/N Liver disease
Y/N Material allergies (latex, metals, etc.)
Y/N Mitral valve prolapse
Y/N Nervous problems
Y/N Psychiatric care
Y/N Premature birth
Y/N Radiation treatment
Y/N Recurrent ear infections
Y/N Respiratory disease
Y/N Rheumatic fever
Y/N Seasonal allergies
Y/N Sensory disorder
Y/N Sickle cell disease/trait
Y/N Speech impairment/delay
Y/N Spina bifida
Y/N Sleep apnea
Y/N Thyroid disease hyper/hypo
Y/N Seizure
Y/N Tuberculosis
Y/N Ulcers / colitis
Y/N Venereal disease
Y/N Vision impairment

Does your child have any special limitations either mental or physical not included above? If yes, describe:

____

Does your child have any drug allergies? Y/N If yes, list all:

____

Does your child take any multivitamins? Y / N If yes, what kind: Chewable Gummy

Does your child take any medications? Y/N If yes, list all:

____

Did you have any problems during your pregnancy? Y/N If yes, describe:

____

Were there any complications with the birth of your child? Y/N If yes, describe:

____

Did you or are you breast feeding your child? Y / N If yes, until what age: ___________

Has your child ever fallen and bumped their mouth or teeth? Y/N If yes, describe:

____

Does your child have an oral habit (pacifier, thumb/finger sucking, tongue thrust, etc.)? Y/N If yes, describe: ____

How many ounces of the following does your child drink a day:

Juice (watered down or straight): ___________

Tap water: ___________

Bottled water: ___________

Gatorade: ___________

Milk/Chocolate milk: ___________

Soda: ___________

Tea/Coffee: ___________

Iced tea: ___________

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the treating dentist to help determine the most appropriate and healthful dental treatment. I understand that if there is any change in medical status I must inform the dentist.

Signature ____ Date: ____________________

Financial Policy

All co-payments are due at the time services are rendered.
As a condition of your treatment by this office, financial agreements must be made in advance. Our office accepts assignment of insurance benefits. We verify eligibility and coverage for all insurances: if your insurance is expected to pay a portion of your bill, we will wait for that portion from them. It is your responsibility to pay any co-pays, deductibles, or any amounts not expected from your insurance at the time treatment is provided. If your insurance company has not paid the full balance within 60 days, the balance of your account will become your responsibility. If you do not have insurance, or if our office does not accept assignment from your insurance company then payment is due in full at the time of treatment.
We are a third party administrator of your insurance carrier and are NOT responsible for how your insurance handles your claims or how benefits are assigned. We can assist in estimating the cost of your portion of treatment, but cannot be responsible for any changes in your insurance policy or benefits used elsewhere. It is your responsibility to let us know if there are any changes to your insurance, if your policy is terminated, or if you have used benefits elsewhere. Please remember that insurance is a contract between you and your insurance company, our office is not a part of this contract. You are responsible for the timely payment of your account.

Our office accepts cash, Visa, MasterCard, Discover, American Express, and Care Credit. We do not accept check payments.

In this office we believe in providing our patients with the utmost care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade to amalgam (metal) fillings, however this is a mercury free office, therefore the patient is responsible for any difference in cost.

X-rays and Photographs Policy

I authorize Woodlake Family Dental to take any x-rays and photographs deemed necessary for the detection and diagnoses of oral decay and disease. I authorize the release of this and any other information to my insurance company necessary to processing my dental claim in accordance with HIPAA regulations.

Cancellation Policy

If you find it impossible to keep an appointment, for consideration of other patient's needs, we ask for at least a 48 hour notice. Appointments cancelled or missed without a 48 hour notice are subject to a fee. We believe the dental appointment represents a shared responsibility for both the doctor and the patient, in order to have quality dental care at an affordable cost these appointments must be kept. If you fail to confirm your appointments, our office reserves the right to cancel your appointment or those of your family members. After two missed appointments, we will no longer be able to reserve appointment time for you in advance.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature ____ Date: ____________________

Acknowledgement of Receipt of Notice of Privacy Practices

I ____, hereby acknowledge receipt of Woodlake Family Dental's Notice of Privacy Practices detailed information about how the office may use and disclose my confidential information.

Patient Name: ______________________________________

Relationship to patient: _______________________________

Signature ____ Date: ____________________

Request for Confidential Communications

Written Communications:

If the address provided on the first page is **not** your home address, please provide us with a street address for purposes of ensuring payment and appointment reminders.

____

The best way for Woodlake Family Dental's staff to contact me is by: (Circle one) Home # Cell # E-mail

Oral Communications:
May we leave a message at the numbers provided for the following?

Home # : Yes / No Cell # : Yes / No

May we leave a message that you need to pre-medicate? Yes / No

May we leave a message that you have a dental appointment? Yes / No

May we leave a message that you require a dental appointment? Yes / No

WOODLAKE FAMILY DENTAL

Informed Consent for Pediatric Dental Treatment

One of our most important parental policies is to "inform before we perform". Before we begin treating your child, we ask your permission for periodic dental examinations, x-rays, dental cleanings and fluoride applications. We also need your permission to perform dental treatments, restorations, and/or appliances as needed to return all to teeth to health and proper function, using local anesthetic and a comfortable mouth prop. The purpose of all these procedures is to gain and maintain dental health, we expect good results although no guarantees as to the results that may be given.

Although our goal is the best oral health for your child, there are some slight risks involved in achieving that goal. Very rarely, dental treatment may be associated with numbness, bleeding, discoloration, soreness, upset stomach, dizziness, allergic reactions, swelling and infection. But ignoring a known dental problem has even greater risks. Not treating existing dental problems in children may result in abscess, infection, pain, fever, swelling and considerable risk to the developing teeth, and may create future orthodontic and gum problems.

A visit to the dental office presents the young child with lots of new and unfamiliar experiences, it us completely normal for some children to react to these new experiences by crying. All efforts will be made to gain the confidence and cooperation of our young patients by warmth, humor, gentle understanding and friendly persuasion. High quality dental care for children is our goal. Quality care can be made very difficult or even impossible, by the lack of cooperation. Behaviors that can interfere with proper dental treatment are hyperactivity, resistive movements, refusing to open the mouth or keep it open and even aggressive or physical resistance to treatment. Aggressive or physical resistance to treatment can be screaming, hitting, kicking, and grabbing the dentist's hands or grabbing our sharp dental instruments.

There are several behavior management techniques that are used in our office to help children get the quality care they need. Let us tell you about them:

a. TELL-SHOW-DO is the use of simple explanations and demonstrations, geared to the child's level of maturity.

b. POSITIVE REINFORCEMENT is rewarding the helpful child with compliments, praise, a hug or a prize.

c. VOICE CONTROL is getting the attention of a noisy child by using firm commands and varying tones of voice.

d. PHYSICAL RESTRAINT BY THE DENTAL TEAM. With an active and noisy child, it is sometimes necessary for the dental assistant to restrain the child's movement by holding the head, arms, hands or legs. The dentist may restrain the child's head by stabilizing between arm and body. A rubber or plastic mouth prop is placed in the child's mouth to prevent closing when the child refuses to open or has trouble keeping the mouth open.

e. PHYSICAL RESTRAINT BY PAPOOSE BOARD OR PEDI-WRAP. The use of this type of restraint is standard care in medicine. The Papoose Board or Pedi-Wrap is the safest and most compassionate way to ensure quality dental treatment of an active child. It may hold arms, body and legs secure with Velcro and cloth wraps during treatment.

f. LAUGHING GAS is the use of nitrous oxide as a safe way to provide dental treatment to the mildly frightened, but helpful children. **Laughing gas calms children, but does not put them to sleep or numb their teeth.** It has few side effects and lasts only as long as the gas is being given through a nose mask. On rare occasions the gas can cause an upset stomach and vomiting.

Beyond these techniques, a child with disruptive behavior may need dental treatment with sedation or treatment in a hospital, which is covered in a separate consent form.

I have read and understand this information on behavior management. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatments in terms appropriate to their age. If any other treatment other than the above is needed it will be discussed with me before beginning such treatment. I understand that I may refuse any or all the above treatments or procedures. I can do this by drawing a line through the objectionable part and writing my initials next to the portion to which I refuse consent. This consent will remain in full force unless withdrawn in writing by the person who has signed on behalf of this minor patient.

Child's name (Print): ____
Parent/Guardian Signature ______________________________________ Date: ________________
Witness: ____