

# Welcome to Fremont Children's Dentistry!

## Patient Information

Patient Name: \_\_\_\_\_ Nickname/Preferred Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Last First MI  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Boy  Girl  
Names and ages of brothers and sisters \_\_\_\_\_

## Responsible Party Information

**Father:** \_\_\_\_\_  Married  Single  Other  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code  
Employer Information: \_\_\_\_\_  
Name Street City State Zip Code  
E-mail address: \_\_\_\_\_ Primary Language Spoken \_\_\_\_\_

**Mother:** \_\_\_\_\_  Married  Single  Other  
Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_ Best time to call: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Apartment #  
City State Zip Code  
Employer Information: \_\_\_\_\_  
Name Street City State Zip Code  
E-mail address: \_\_\_\_\_ Primary Language Spoken \_\_\_\_\_

## Insurance Information

### Primary

Insurance Plan Name and Address: \_\_\_\_\_  
Name of subscriber: \_\_\_\_\_  
Last First MI  
Subscriber's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber's Address: \_\_\_\_\_  
Street City State Zip Code  
Subscriber's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Patient's relationship to subscriber:  Self  Spouse  Child  Other \_\_\_\_\_

### Secondary

Insurance Plan Name and Address: \_\_\_\_\_  
Name of subscriber: \_\_\_\_\_  
Last First MI  
Subscriber's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Subscriber's Address: \_\_\_\_\_  
Street City State Zip Code  
Subscriber's Employer Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street City State Zip Code  
Patient's relationship to subscriber:  Self  Spouse  Child  Other \_\_\_\_\_

## Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Newspaper  School  Work  Other \_\_\_\_\_  
Name of person or office who referred you to our practice: \_\_\_\_\_

## Health Information

Patient Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name child goes by: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Weight: \_\_\_\_\_ Lbs

1. Has there been any change in your child's general health in the last year?..... Yes  No
2. Has your child been hospitalized in the last two years? ..... Yes  No
3. Does your child have a heart condition or heart murmur? ..... Yes  No
4. Have you been told that your child should have antibiotics before dental visits? ..... Yes  No
5. Does either your family or your child have a history of complication from general anesthesia?  Yes  No
6. Has your child ever had radiation therapy? .....  Yes  No
7. Are your child's immunizations up to date? ..... Yes  No
8. If applicable, is the patient taking birth control medication? ..... Yes  No
9. Is the patient pregnant? .....  Yes  No
10. Date of last tetanus vaccination: \_\_\_\_\_
11. Date of last physical exam: \_\_\_\_\_ Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

\*If you marked yes to any of the above, please explain: \_\_\_\_\_

12. List all of your child's allergies, include adverse reactions to any drugs, medication, latex, foods: \_\_\_\_\_

### Has your child ever been diagnosed with any of the following? Please check those that apply:

- |   |   |   |  |
|---|---|---|--|
| <input type="checkbox"/> ADD/ADHD             | <input type="checkbox"/> Diabetes               | <input type="checkbox"/> Jaundice/Liver disease | <input type="checkbox"/> Sickle Cell anemia          |
| <input type="checkbox"/> AIDS or HIV positive | <input type="checkbox"/> Developmental Delay    | <input type="checkbox"/> Jaw joint pain         | <input type="checkbox"/> Skin conditions             |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Ear disorders          | <input type="checkbox"/> Kidney Disease         | <input type="checkbox"/> Speech Delay/Therapy        |
| <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Eating disorders       | <input type="checkbox"/> Lung Disease           | <input type="checkbox"/> Stomach Problems            |
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Endocrine disorders    | <input type="checkbox"/> Mental Retardation     | <input type="checkbox"/> Thyroid problems            |
| <input type="checkbox"/> Autism               | <input type="checkbox"/> Epilepsy/Seizures      | <input type="checkbox"/> Organ Transplant       | <input type="checkbox"/> Tonsils/Adenoids surgery    |
| <input type="checkbox"/> Behavioral problems  | <input type="checkbox"/> Eye disorders          | <input type="checkbox"/> Pacemaker              | <input type="checkbox"/> Tuberculosis                |
| <input type="checkbox"/> Blood disease        | <input type="checkbox"/> Excessive Bleeding     | <input type="checkbox"/> Premature birth        | <input type="checkbox"/> Tumors                      |
| <input type="checkbox"/> Bone/joint problems  | <input type="checkbox"/> Head Injuries          | <input type="checkbox"/> Psychiatric treatment  | <input type="checkbox"/> Upper respiratory infection |
| <input type="checkbox"/> Cancer/Tumor         | <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Radiation Treatment    |  |
| <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Hepatitis (any type)   | <input type="checkbox"/> Respiratory Problems   |  |
| <input type="checkbox"/> Chemical Dependency  | <input type="checkbox"/> High blood pressure    | <input type="checkbox"/> Rheumatic Fever        |  |
| <input type="checkbox"/> Cleft lip/palate     | <input type="checkbox"/> Injuries to Face/Mouth | <input type="checkbox"/> Seizures               |  |

Please explain the condition further and/or list any other condition your child might have: \_\_\_\_\_

List any medications your child is currently taking: \_\_\_\_\_

## Dental History information

- Is this your child's first visit to the dentist?..... Yes  No Previous Dentist: \_\_\_\_\_  
Date of last visit: \_\_\_\_\_ Reason for visit? \_\_\_\_\_ Date of last x-rays: \_\_\_\_\_  
Does the patient use a pacifier or do they suck their thumb?  Yes  No Are they still using a baby bottle?..... Yes  No  
Have they had orthodontic treatment?..... Yes  No What does your child normally drink? \_\_\_\_\_  
Do they snore when they sleep? ..... Yes  No Do they have difficulty opening their mouth?  Yes  No  
Are they grinding their teeth?..... Yes  No Any gum problems that you are aware of?..... Yes  No  
Has your child had a toothache recently? ..... Yes  No If yes, please explain: \_\_\_\_\_  
Does having dental treatment make your child nervous?..... Yes  No If yes, please explain: \_\_\_\_\_  
Have they ever had a bad experience in the dental office?.... Yes  No If yes, please explain: \_\_\_\_\_  
Has ever had any complications following dental treatment?.. Yes  No If yes, please explain: \_\_\_\_\_  
How many times a day does the child brush their teeth? \_\_\_\_\_ By whom? \_\_\_\_\_  
How do they normally do at the dentist? \_\_\_\_\_ How do think your child will act toward the dentist? \_\_\_\_\_  
Is there any additional information about your child you would like the dentist to know?..... Yes  No  
If yes, please explain: \_\_\_\_\_

**To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any change in my child's health, I will inform the doctors at the next appointment without fail.**

Signature of parent or legal guardian \_\_\_\_\_ Date: \_\_\_\_\_

**For Dentist Use Only**

Update and Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Update and Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Update and Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Update and Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Consent for Treatment**

As a minor child, it is necessary that signed permission be obtained from the parent or legal guardian before any dental treatment can begin. **It is also necessary for minor patients to be accompanied by an adult of legal age and who can give legal consent for treatment at each appointment.**

It is our intent that all care shall be of the best possible quality for each child. Providing high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open 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 child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding. We treat our patients the way we would like our own children to be treated.

There are several behavior management techniques that are used by dentists to gain cooperation of child patients and 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: **(please initial that you have read these items. Note that we do not use all of these techniques, they are included for your information).**

- **MODELING:** The environment that the patient will be in is demonstrated prior to the first appointment. (Initial) \_\_\_\_\_
- **TELL-SHOW-DO:** The dentist or assistant explains to the child what is to be done using simple terminology and 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 fingers. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior. (Initial) \_\_\_\_\_
- **POSITIVE REINFORCEMENTS:** This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, or a prize. This is by far our favorite because it works the best. (Initial) \_\_\_\_\_
- **VOICE CONTROL:** The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command. Every parent has at one point used this scientifically proven technique, also known as the "knock it off". (Initial) \_\_\_\_\_
- **MOUTH PROPS:** A rubber or plastic device is used between the teeth to assist the patient in keeping their mouth open and preventing them from getting their mouth tired. This can also prevent "accidental" injury to the dentist's fingers. (Initial) \_\_\_\_\_
- **PHYSICAL RESTRAINT BY THE DENTIST:** The dentist restrains the child from potentially harmful movement. Keep in mind that this is not a wrestling match and restraint is only temporary and an emergency measure. You will be immediately contacted if the patient requires restraint. (Initial) \_\_\_\_\_
- **PHYSICAL RESTRAINT BY THE ASSISTANT:** The assistant restrains the child from movement by holding the child's hands, stabilizing the head and/or controlling leg movement. Sorry, we will not hold anyone down, that is not our job. (Initial) \_\_\_\_\_
- **PEDI-WRAPPS:** These are restraining devices for limiting the disruptive child's movements to prevent injury and to enable the dentist to provide necessary treatment. The child is wrapped like a "burrito" and placed in a reclined dental chair. We do not have one of these devices in our office; we prefer not to accomplish treatment in this manner. (Initial) \_\_\_\_\_
- **SEDATION:** Sometimes medications may be used to relax a child who is apprehensive or nervous. These drugs may be administered orally, or by a gas (nitrous oxide and oxygen). Your child will not receive nitrous oxide without you being further informed and obtaining your specific consent for such a procedure. The child does not become unconscious. The use of nitrous oxide requires a different appointment. We do not offer oral sedation. In Dr. Rothe's opinion, it's not worth the risk. (Initial) \_\_\_\_\_

I hereby state that I have read and understand this consent, and that all questions about the procedure or procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. I give my consent for the administration of local anesthetics and nitrous oxide (laughing gas). If my child ever has a change in his/her health or his medications change, I will inform the doctor at the next appointment without fail. At no time will care be rendered to a child without informing the parent or guardian of such care. For specific procedures, further information will always be provided. I further understand that this consent will remain in effect until such time that I choose to terminate it by written request.

\_\_\_\_\_  
Signature of parent or legal guardian

\_\_\_\_\_  
Date

## Fremont Children's Dentistry Office Policies

### Parents present in the treatment areas:

Fremont Children's Dentistry does not have a specific policy on parental presence during treatment. We greatly appreciate the trust you have placed in us to treat the most precious member(s) of your family. Research has repeatedly shown that children under the age of four may experience some stranger anxiety and therefore it is best if they are accompanied by a family member. Children older than four, however, consistently do better if the parent is not present during treatment. This allows for unobstructed communication between the dental team and the patient. We do not support the concept of having the parent leave the treatment area after the patient exhibits unwanted behavior because the young patient may take this as a punishment. We will treat your child the way we would like our own children to be treated by other health professionals and therefore we will ask for your presence as a "silent" observer if behavior becomes an issue. Please be aware that your presence may not allow us to perform any treatment and we may have to schedule a different appointment. Again, we appreciate your confidence and trust.

### No-Show/Failed appointments:

We request that you give us at least a 48 hour notification if you are unable to keep an appointment. Not only is this a general courtesy, but this allows us to schedule other patients who may be waiting to be seen. Repeated failure to show for appointments will not allow us to schedule any more treatment for your child. We understand that circumstances will occur which may keep you from attending an appointment, however, **after the second failed appointment without proper notification, we will assist you in making arrangements to have your families care transferred to another dentist.**

### Late arrivals:

We value your time, therefore we make every effort to stay on schedule. Arriving late to your child's appointment does not allow time for the treatment planned for that appointment. If you arrive later than 10 minutes we will ask you to reschedule on a different date. Sometimes it is better to reschedule than to keep your family waiting. Calling to tell us that you will be late will be considered a failed appointment.

### Financial Responsibility:

Full Payment is expected at the time of service. Major credit cards, checks and cash are accepted. For patients with dental insurance, the co-insurance, deductible and non-covered expenses are due at the time of service. If you provide us with your insurance information and card, as a courtesy to our patients, we will complete insurance claim forms at our expense. The office will file to your insurance company the portion which should be covered by them. Billing by our office requires staff time and materials which result in higher fees. **To avoid any misunderstandings we ask that you take care of the financial portion at each appointment.**

Your signature below signifies that you have read and understand the policies explained in these paragraphs. By signing this form, you accept financial responsibility for this patient, authorize the release of any information necessary to process insurance claims and authorize insurance payments to Dr. Vincent Rothe. You agree to inform the appropriate staff of Fremont Children's Dentistry of any changes in the financial arrangements prior to treatment.

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## Confidentiality Policy

I have read and agree with the notice of Privacy Practices for Fremont Children's Dentistry (HIPPA form).

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