A Kidz Dental Zone of Hood River

Thank you for choosing our practice for your child's dental care. We believe that you and your child deserve the very best care we can provide. It is our pledge to treat all of the patients entrusted to our care as if they were our own children.

So that we may best serve you please complete the enclosed forms before your appointment and bring them with you. The most important document in the packet is the medical history. Complete it as accurately as possible and feel free to make any comments on the form you think may be helpful in understanding your child's health status.

As a Pediatric practice we use a completely different vocabulary when explaining procedures to children and very anxious patients. For us to be most effective we ask that you briefly describe what a dentist does and what the child can expect; but please avoid using terms like: it won't hurt, shot, needle, pain or sharp. Avoid words and descriptions that are negative. We strive to accurately describe what a patient is going to experience using terms that are more descriptive of what will actually happen and express them on a level appropriate for the child's age.

Another big difference between our practice and other dentists is that we encourage the parent to accompany the child into the treatment area. There are some guidelines that we ask you to follow. Please refrain from speaking to the child when the dentist is talking. Children can only respond to one person at a time and an interruption may result in an important direction being missed. Please remain seated in the chair provided for you. If asked to leave please do so as quietly and quickly as possible. Feel free to ask any questions you may have. We want you, the parents, to be as informed as possible with regard to the treatment being provided to your child.

Very young children often cry even for simple examinations. This is normal behavior and in no way does it upset us, and you should not be embarrassed nor should you try to quiet the child. Crying actually facilitates our work since it is usually done with the mouth wide open.

Again, thank you for entrusting your child's care to us. If you have any questions please call.

Sincerely,

The staff of *A Kidz Dental Zone* of Hood River

CHILD'S CONFIDENTIAL INFORMATION

Child's Full Name:		Age:	DOB:	Sex: F M
Preferred Name:		Hobbies/Pets:		
Child's Home Address:				
City:	State:	Zip:	Phone #:	
Child's Soc. Sec. No.:		School:		Grade:
Who does the child live with?___ Both Parents ___Mother ___Father ___Other:				
Child's Physician:			Phone #:	
Address of Physician:				

Referred by _____

PARENTAL CONFIDENTIAL INFORMATION

Mother/Guardian's Full Name:			DOB:
Relationship to Child: ___Mother ___Step-Mother ___Guardian		Soc. Sec. No.:	
Residential Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Email Address:		Drivers License:	
Occupation:	Employer:		
Work Address:			
Home Phone:	Work Phone:	Cellular Phone:	

Father/Guardian's Full Name:			DOB:
Relationship to Child: ___Father ___Step-Father ___Guardian		Soc. Sec. No.:	
Residential Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Email Address:		Drivers License:	
Occupation:	Employer:		
Work Address:			
Home Phone:	Work Phone:	Cellular Phone:	

EMERGENCY CONTACT

Name:	Relationship:	Phone #:
Name:	Relationship:	Phone #:

Signature of Parent/Guardian: _____ *Date:* _____

DENTAL HISTORY

Patient Name:	***DOB:***	***Parent/Guardian Name:***

Date of child's last dental visit? | Name of Dentist?

Were any x-rays or radiographs taken? Yes No

At what age did your child discontinue the bottle or nursing? _____years _____months

Does your child have any mouth habits (thumb/finger sucking, pacifier, grinding, etc)? Yes No
If yes, please explain.

Does your child eat between meals? Yes No

Does your child eat sweets, such as candy, soda pop, chewing gum? Yes No

When does your child brush his/her teeth?
Upon Rising After eating any food Right after meals Before going to bed

How many times a day does your child brush? _____

Does your child floss? Yes No
If yes, how often? _____

How does your child receive Fluoride?
Community Water Well Water Fluoride Drops or Tablets Fluoride Rinse or Gel

Does an adult assist your child with brushing, flossing or fluoride? Yes No

Have cavities been noted in the past? Yes No

Have any teeth (baby or permanent) been removed or extracted? Yes No

Have there been any injuries to teeth, such as falls, blows, chips, etc? Yes No
If yes, please explain.

Has your child had TMJ (jaw joint) problems? Yes No
If yes, please explain.

Has your child had any problem with dental treatment in the past? Yes No
If yes, please explain.

Has anyone in the family, including parents, had orthodontics? Yes No

Has your child ever received a local anesthetic? Yes No

Has your child ever had occlusal sealants? Yes No

Does your child think there is anything wrong with his/her teeth? Yes No
If yes, please explain.

If there is additional information that you feel might be of value to us, please comment.

Parent/Guardian Signature: ***Date:***

Health History

Patient Name:	***DOB:***	***Parent/Guardian Name:***
Primary Care Physician (name & number):		

*Please **check** any of the following that pertain to your child.*

HEART	Heart Murmur Mitral Valve Prolapse Rheumatic Fever Congenital Heart Defect Low/High Blood Pressure Heart Surgery Other Heart Problem , If so, please list: _____
KIDNEY	Bladder Urinary Problems
LIVER/GI	Stomach/Intestinal Ulcers Gastritis Colitis Diarrhea Jaundice Hepatitis Liver Disease Reflex (GERD)
ENDOCRINE SYSTEM	Diabetes Type_____ Thyroid Disease
HEMATOLOGIC	Blood Transfusions Date(s): _____ Anemia Hemophilia Leukemia Sickle Cell Disease Prolonged Bleeding
LUNG/BREATHING	Hay Fever Sinus Trouble Allergies or Hives Asthma Chronic Cough Emphysema TB or Tuberculosis
NEUROLOGICAL	Nervous Disorder Mental Disorder Cerebral Palsy Seizure Disorder/Epilepsy Fainting Retardation Brain Injury Developmental Delay Headaches Speech Disorder ADHD Autism
HEARING/EYE	Vision Problems Glaucoma Eye Pain Earaches Hearing Loss
DERMAL/ MUSCULOSKELETAL	Rash Allergy to Latex Arthritis Fever Blisters/Cold Sores Ulcers

Does your child have any disease, condition or other health problem not listed above? If yes, please list.	Yes	No
****Is your child currently taking any medication, including vitamins & herbal supplements? If yes, please list with dosages.***	Yes	No
Has your child been hospitalized since birth? If yes, why & when?	Yes	No
Has your child ever has surgery? If yes, why & when?	Yes	No
Has your child had radiation or chemotherapy? If yes, why & when?	Yes	No
Does your child use tobacco (any form)?	Yes	No
Does your child have AIDS or has he/she tested HIV positive?	Yes	No
Is your child up to date with immunizations?	Yes	No
Does your child have any allergies to medications or food? If yes, please list.	Yes	No
Is your child adopted? Does he or she know?	Yes Yes	No No
FEMALES: Is there any possibility of pregnancy? Does she take birth control medication?	 Yes Yes	 No No

Patient/Guardian Signature	**Reviewer**	**Date**
1. _____	_____	___/___/___
2. _____	_____	___/___/___
3. _____	_____	___/___/___
4. _____	_____	___/___/___

INSURANCE INFORMATION

Payment is required for services rendered at the time of that treatment.

Method of Payment: _____Cash _____Check _____Credit Card (MC or VISA) _____CareCredit

Primary *Dental* Insurance Co:			
Address:		Phone #:	
Policy #:	Group #:	Employer:	
Name of Subscriber:	Soc. Sec. No.:		DOB:

Secondary *Dental* Insurance Co:			
Address:		Phone #:	
Policy #:	Group #:	Employer:	
Name of Subscriber:	Soc. Sec. No.:		DOB:

Primary *Medica*l Insurance Co:			
Address:		Phone #:	
Policy #:	Group #:	Employer:	
Name of Subscriber:	Soc. Sec. No.:		DOB:

Secondary *Medical* Insurance Co:			
Address:		Phone #:	
Policy #:	Group #:	Employer:	
Name of Subscriber:	Soc. Sec. No.:		DOB:

The policy of our office is that the parent who brings the child for treatment is responsible for all fees for treatment/services rendered.

Financial Agreement:

I understand that I am responsible for the payment of all fees for dental treatment for the patient named. I understand that I am responsible for any fee not covered by patient's dental or medical insurance. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

Child's name: _____

_____ _____

Print name *Print name*

_____ _____

Signature *Signature*

KidZ DENTAL ZONE

Financial Policies and Agreement

Payment/Insurance Policy

In an effort to keep dental costs down while maintaining a high level of professional care, We file insurance claims as a courtesy to our patients. **Patients with insurance will be required to pay, at time of service all estimated patient portion.** This amount is an estimate of your copayment and we work hard to make this as accurate as possible. However, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You are responsible for deductibles, co-payments, coinsurance and all dispute resolution will be with your insurance company.

Our office accepts cash, check, Visa and Mastercard. Also, as an added benefit to you we offer monthly payment plans through CareCredit and In-house financing. Please inquire with our financial coordinator for information on your payment options. As a courtesy to our patients, we provide a 5% discount when the bill is paid in full at the time of service with either cash or check.

Oral Sedation/ Operative-Surgical Deposits

When scheduling an oral sedation or operative/surgical procedure, a deposit of $200.00 for oral sedation or $400.00 for operative/surgical will be collected. This deposit will be refunded upon such time as scheduled procedure is performed, and account balance is clear and current. The patient's expected portion of charges(coinsurance and /or deductibles) will also be collected before the day of procedure.

Missed Oral Sedation/Operative –Surgical Policy

Due to our high demand for oral sedation and operative-surgical appointments, we have implemented a "Missed Oral Sedation/Operative-Surgical Appointment Policy" to encourage our patients to keep their scheduled appointments. If you cannot attend your scheduled appointment, you **must call** to cancel or reschedule a minimum of **72 hours in advance.** If we do not have a **72 hour advance notice** of cancellation, you will be charged a **$200.00 non-refundable "Missed Surgical/Operative Appointment Fee".**

We realize that sometimes illness can come on very quickly, so we ask that you contact us immediately and schedule your child for a wellness evaluation prior to the procedure.

Missed Appointment Policy

We work diligently to be able to see all of our patients in a timely manner, as such missed appointments leave us with a hole in providing care to children in our community. Our practice strives to keep our pricing very competitive and missed appointments by some, hurt all of our patients. The financial result on us can be significant. Therefore, we have instituted a "Missed Appointment Policy" which states that **appointments not cancelled with 48 hours minimum advance notice will be charged a fee of $50.00.**

I understand that I am responsible for the payment of all fees for dental treatment for the patient named below. I understand that I am responsible for any fee not paid by the patient's dental or medical insurance. The undersigned agrees that should the account be referred to an attorney for collection, the fees incurred will be paid by the responsible party.

Parent/Legal Guardian Signature **Date**

RECEIPT OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

ACKNOWLEDGE OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I, _____ , have received a copy of this office's Notice of

Privacy Practices pertaining to my child,_____ 's treatment.

Parent/Guardian Signature: _____Date: _____

PARENT/GUARDIAN GIVING CONSENT

To The Parent/Guardian,

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of protected health information to carry out treatment, payment activities and healthcare operations.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Parent/Guardian Signature: _____Date: _____

Address:_____ Phone #:_____

SIGN BELOW "ONLY" IF YOU WISH TO REVOKE CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Parent/Guardian Signature: _____Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

KidZ DENTAL ZONE

A Kidz Dental Zone of Hood River
419 State Street
Hood River, Oregon 97031
Phone: 541.387.8688

Authorization to Transfer Medical/Dental Records

I hereby authorize _____, to furnish medical/dental information concerning (patient's name): _____ to A Kidz Dental Zone of Hood River, 419 State Street, Hood River, OR 97031.

Any and all information may be released, including, but not limited to, all radiographs, treatment plans, demographic information, mental health records, drug and alcohol abuse records and HIV test results, if any, except as specifically provided below:

_____

I understand that I may receive a copy of this authorization.

Signature: _____ Date: _____

If not signed by the patient, please indicate relationship:

1. Parent or guardian of minor patient
2. Guardian or conservator of an incompetent patient
3. Beneficiary or personal representative of deceased patient

PEDIATRIC BEHAVIOR MANAGEMENT

Pediatric Dentists are especially trained in the care and behavior management of children. Part of their specialty training includes child and adolescent emotional and psychological development. We believe in approaching children in a gentle calming manner. The Doctor Patient relationship demands a certain level of cooperation from the patient. Appropriate cooperation enables us to provide quality care safely. A great deal of effort goes into successfully achieving this goal of safe, high quality care.

The dynamics of the dental office is complex and requires team work between the dentist, staff, child and parent. The team leader is by necessity the dentist, as he is responsible legally and morally for safely and quality. Every effort is made to make the experience as pleasant and comfortable for your child as possible. Most children will readily accept dental care as a natural and nonthreatening part of life. Some children are, by their nature, resistant, recalcitrant or otherwise uncooperative for even simple procedures and may require different approaches to behavior management. The initial purpose of dental exam is to see how the child is going to react to the dentist and staff. The parent's responsibility is to grant permission for the dental staff to interact with the child and to not interrupt unless asked to become involved. This is a difficult step for many parents and requires a level of trust in the dentist and his staff. By intervening on the child's behalf the parent sends the message that dental care is not important and can be avoided if the child wants. Also, by becoming involved you prevent the dentist and staff from effectively evaluating the child's behavior and response to determine the best course of action for that child.

There are certain rules of behavior that are essential in guaranteeing successful completion of dental care. Sometimes it becomes necessary for the dentist or a staff member to become verbally or physically authoritative to encourage an otherwise capable youngster into carrying out their part in the team dynamics. These moments will always be accompanied with positive reinforcement for any appropriate behavior and with words of comfort and reassurance.

There are several behavior management techniques that are recognized by pediatricians and pediatric dentists as appropriate for controlling dangerous or disruptive behavior in the clinical setting. Most children respond very well to these techniques. None of these behavior management techniques have resulted in long term "psychological trauma". Children have a basic need for adults to place certain restrictions on behavior. They have more difficulty handling too much freedom. Children feel more secure when adults demonstrate care and concern for them by placing and enforcing restrictions. Settings limitations teaches them the difference between appropriate and inappropriate behavior. We approach these management techniques in a matter-of-fact or natural manner. At no time do we present what we are doing as some sort of punishment, but rather we seek to help the child to cope with what may or may not be a stressful situation.

Some of the methods we employ to gain cooperation are:

a. Tell-show-do.
b. Positive reinforcement.
c. Mouth props.
d. Voice control.
e. Passive and active physical restraints.
f. Conscious sedation.
g. General anesthesia.

Obviously, we attempt to find and use the least authoritative technique to fit the child and the situation. Sedatives and general anesthesia present risks to the child that other forms of management do not. These risks include excitation, nausea/vomiting, cessation of breathing, heart irregularities, brain damage and death. These risks are very, very slight, but they do exist. The risks of not treating dental disease actually carry a higher threat to the child. These risks include pain, swelling, fever, poor nutrition, poor academic performance, damage to permanent teeth, kidney and heart valve infections, sinus and brain infections, and death. You are encouraged to discuss any aspects of these behavior management techniques with the dentist or staff.

I have read and understand the above information.

Printed name of parent/guardian: _____

Signature: _____

Date: _____

KidZ DENTAL ZONE

PRACTICE TERMINOLOGY

Dear Parent/Guardian:

In order to improve the opportunity for your child to have a positive experience in our office, we are selective in our use of words. We try to avoid words that might worry the child due to previous experiences. Please support us by NOT USING negative words. Use positive words.

DON'T USE	*OUR EQUIVALENT*
*Shot	*Sprayer or Sleepy Juice
*Needle	*Sprayer Tip
*Medicine	*Juice
*A Drill	*A Whistle
*Drill on Teeth	*Clean on Tooth, Chase Away Sugar Bugs
*Pull a Tooth	*Wiggle a Tooth
*Decay, Cavity	*Sugar Bug or Tooth Bug
*Examination	*Count Teeth
*Tooth Cleaning	*Tickle the Teeth
*Dental Pick (Explorer)	*Silver Pencil
*Rubber Dam	*Rain Coat
*Gas	*Magic Air or Laughing Gas
*Suction	*Straw
*Water/Air Sprayer	*Squirt Gun

This will also help you understand your child's description of the dental experience.
Our intention is not "fool" the child but rather to create and experience that is positive.

We appreciate your cooperation in helping us build a good attitude for your child!

KidZ DENTAL ZONE

AUTHORIZATION FOR CONSENT TO MEDICAL CARE OF MINOR CHILDREN

I/We:

Name:	*Address:*	*Telephone #'s:*

are the parent(s) or legal guardian(s) and legal custodian(s) of the following minor child/children:

Name:	*DOB*	*Special Medical Concerns*

I/We hereby authorize:

Name:	*Address:*	*Telephone #'s:*

With whom I/we am/are temporarily entrusting the care and custody of my/our minor child/children, to consent to any x-ray, examination, anesthetic, medical, surgical, or dental diagnosis or treatment and hospital care to be rendered to the minor(s) under the general or specific supervision and on the advice of any physician, surgeon, or dentist licensed to practice medicine, surgery, or dentistry.

This authorization shall be effective from the date signed through _____, 20 __, which must not exceed six (6) months from the date signed.

Signatures:

_____ _____

Parent/Guardian *Date*

_____ _____

Parent/Guardian *Date*

_____ _____

Witness *Dat2*

A Kidz Dental Zone

Dear Parents,

A Kidz Dental Zone is proud of your child for doing an outstanding job keeping their teeth clean! We enjoy recognizing your child's accomplishments and childhood celebrations! In honor of your child, we would like to display his/her picture on our digital photo frame, no cavity club, clinic brochures, and/or clinic advertising as well as our AKDZ Facebook page to recognize your child's great effort!

Please sign this consent form and return to A Kidz Dental Zone. We are happy to provide a copy for your records as well.

I, _____ am the parent/guardian of _____ and I will allow A Kidz Dental Zone to display my child's photograph in honor of his/her great dental habits and special celebrations.

Thank you for allowing us to enjoy your child's exciting dental accomplishment!

419 State Street, Hood River, OR 97031
Tel: (541) 387.8688