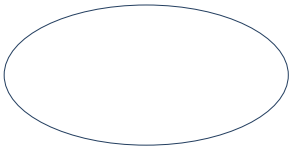
Santa Maria Pediatric Dental Group

We are proud to provide the quality, comprehensive care your child deserves!



Today's Date: _____

Patient Name:_____**DOB:**_____

Health Information: (check any that apply)

Allergic to:	Craniofacial condition	Mental Retardation	Stroke
	Cystic Fibrosis	Muscular Dystrophy	Syndrome—List:
	Diabetes	Orthopedic Disorder	
Arthritis	Drug/ Alcohol Abuse	Pacemaker	Transfusions
Asthma	Gastrointestinal Disorder	Pregnancy	Tuberculosis
Attention Deficit Disorder	Hearing Loss/Deaf	Psychiatric Condition	Vision Disorder/Blind
Autism	Heart Disease	Respiratory Disease	**Other—List:**
Blood/Bleeding Disorder	Heart Murmur	Rheumatic Fever	
Brain/ Spinal Injury	Hepatitis	Seizures/Epilepsy	
Cancer	HIV/AIDS	Sickle Cell Disease	
Cerebral Palsy	Kidney Disease	Speech/Language	
Cleft Lip/Palate	Liver Disease	Spina Bifida	

• Is this the patient's first visit to a Dentist?	If not, please provide previous Dentist Name/last visit below	☐ Yes	☐ No
• Was previous dental experience favorable?	If not, explain below	☐ Yes	☐ No
• Does the patient have a dental problem today?	If yes, explain below	☐ Yes	☐ No
• Who brushes your child's teeth?		☐ Child	☐ Adult
How often (daily) Circle one: Brush: 1x 2x Floss: 1x 0x Fluoride toothpaste: Yes No			
• Is your child emotionally disturbed, developmentally disabled, unable to concentrate or unable to understand directions?		☐ Yes	☐ No
If yes, describe:			
• Is your child taking fluoride drops or tablets at this time?		☐ Yes	☐ No
List any previous exposure to fluoride (include bottled water):			
• Does your child have any habits? Thumb Sucking, Nail Biting, Mouth Breathing, Baby Bottle, Pacifier, Grinding		☐ Yes	☐ No
If yes, explain which or list others			
• Has the patient ever been admitted to a hospital or required Emergency Care?		☐ Yes	☐ No
If yes, explain:			
• Is the patient under the care of a physician for anything other than routine care?		☐ Yes	☐ No
If yes, explain:	Dr:	PH:	
• Is the patient taking any medications, including herbal supplements?		☐ Yes	☐ No
If yes, list:			
• Is there any other information we should know about your child?		☐ Yes	☐ No
If yes, explain:			

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

Patient's Name: _____ Date: _____

Informed Consent

Santa Maria Pediatric Dental Group wants you and your child's visit to be both educational and enjoyable. Therefore, we request that you read this consent form carefully. State Law requires us to obtain your consent for your child's proposed dental treatment.

☒ Consent to receive dental treatment: I consent and authorize Santa Maria Pediatric Dental groups and their employees to preform upon my child a dental examination, cleaning, application of topical fluoride, and necessary radiographs in order to assist in the provision of the necessary dental treatment for my child. In addition any photos taken for office use. (Examples cavity free club, game winners, etc.)

Delaying treatment may allow dental disease to progress to an emergency situation, including abscess formation, infection, pain, fever, risk to the developing permanent teeth, or contribute to a long-term dental problem.

The most common complications associated with pediatric dental treatment include nausea, prolonged numbness and bruising following the administration of local anesthesia. Less common complication include, but are not limited to: infection, swelling, prolonged bleeding, vomiting, allergic reactions, nerve injuries, further degeneration of restored teeth, fracture of teeth during extraction requiring surgical treatment, brain damage and even loss of bodily function or life.

I understand that during the course of the patients treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practices of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives at Santa Maria Pediatric Dental Group.

I understand that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration or procedures and instruments, using variable voice tone and loudness.

The above treatment has been discussed with me. No guarantee or assurance has been made as to the results that may be obtained from this treatment. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I authorize this treatment and any such additional procedures considered necessary on the basis of findings during treatment.

Parent Signature: _____ Date: _____

INFORMED CONSENT FOR ANXIETY REDUCING TECHNIQUES

It is our intent to provide the best possible quality of professional care for each dental patient seen in our offices. Every effort will be made to obtain the cooperation of dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. Should the child dental patient exhibit signs of anxiety we will resort to the most frequently used pediatric dentistry behavior management techniques, to obtain their confidence and cooperation. These Non- Pharmacologic techniques include:

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 finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive Reinforcement: This technique rewards the child who displays any behavior which is desirable. Rewards included compliments, praise, a pat on the back, or a prize.

I acknowledge that I have read and understand this consent form.

Parent Signature: _____ Date: _____

Doctor's Signature: _____

CHILD'S Information:

Patient Name: ☐ Male ☐ Female	Nickname:
	Birthdate: Age:
School:	Grade:
Hobbies:	

How did you hear about our practice? **Radio?** Circle SUNNY 102.5 COUNTRY FM · MEGA 97.1 · THE BEAT · LA LEY 100.3 · LA BUENA

Other:____

CHILD'S CURRENT PEDIATRICIAN:____

Phone #: ______________________________ Date of Last Exam: ________________________

PARENT/GUARDIAN INFORMATION ***(Information will only be released to persons listed below)***

Parents' Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated

☐ **Mother** ☐ **Step-Mother** ☐ **Guardian**	☐ **Father** ☐ **Step-Father** ☐ **Guardian**
Name:	Name:
Home Address: street APT#	Home Address: street APT#
CITY ST ZIP	CITY ST ZIP
Home Telephone: ( )	Home Telephone: ( )
Cell Phone: ( )	Cell Phone: ( )
e-mail:	e-mail:
Date of Birth:	Date of Birth:
SS# *(REQUIRED[1])* ☐☐☐ – ☐☐ – ☐☐☐☐	SS# *(REQUIRED[1])* ☐☐☐ – ☐☐ – ☐☐☐☐
Employer:	Employer:
Occupation:	Occupation:
Work PH:	Work PH:
Dental Insurance at Mother's Employer:	Dental Insurance at Father's Employer:
Name:	Name:

Who is accompanying the patient today? Name: Relation:

In case of emergency contact(outside of home) Name: Phone:( )

OFFICE POLICIES:

BILLING YOUR INSURANCE:

We are happy to assist you in obtaining the maximum benefit from your dental insurance plan. As a courtesy we will file your dental insurance claim for you and accept assignment of payment. Some insurance companies recommend a pre-treatment authorization for the dental treatment to be provided. We will attempt to estimate any expenses prior to your visit to our office

SOCIAL SECURITY NUMBER[1]:

We pride ourselves in keeping personal information private and secure (HIPPA). Your SSN often allows us to verify benefits and process claims more accurately. **If you do not provide your SSN, we will still provide all necessary care; however, full payment is required at time of service**. We will then provide you an insurance claim with all services rendered for you to process on your own behalf

DEPOSIT POLICY:

All treatment that includes nitrous, sedation, and/or iv/general anesthesia **require a deposit before booking of treatment appointments**

PAYMENT POLICY:

Please be prepared for any deductible, co-pay, or other expenses at the time of service. We do not bill former spouses; the parent who has brought the patient is responsible for payment. For your convenience, we accept CASH, CHECK, CREDIT & DEBIT CARDS, as well as offering NO- or LOW-INTEREST Financing through CARE CREDIT.

APPOINTMENTS –and- CANCELLATION POLICY:

We will make every effort to see that you are notified of your child's impending appointment. In addition, a postcard reminder will be mailed approximately 2-4 weeks prior to your recall visit, and a phone call reminder the day before. If you must cancel your appointment, please allow at least 24 hours notice when possible. **If you don't show up to a scheduled appointment or give 24 hour notice there will be a minimum charge of $25.**

TREATMENT AREA POLICY:

Parents are encouraged to accompany their child to the Treatment Area for his/her first visit. This parent/guardian must be a silent observer. This will aid in a positive dental visit for your child. **We appreciate parent involvement but due to limited space we ask that one parent is allowed back including no other children/siblings per dental suite.**

PATIENT RECORDS:

California Health and Safety Code Section 1231000-123149 stipulates you are entitled to receive copies of chart notes and/or radiographs after written request and associated replication fees have been paid. **THERE IS AN ADMIN FEE OF $25 FOR DUPLICATION OF RECORDS THAT ARE TO BE SENT BY PAPER OR ELECTRONICALLY.**

CELL PHONE USE:

Please refrain from cell phone (including photos, video, and correspondence) use while your child is in the dental suite. Both our staff and doctors prefer their privacy while treating your child.

I acknowledge that I have read and understand Santa Maria Pediatric Dental Group's office polices.

Parent signature:_____Date:_____

REQUIRED SIGNATURES:

INSURANCE ASSIGNMENT, AUTHORIZATION and FINANCIAL RESPONSIBILITY:

I hereby authorize Santa Maria Pediatric Dental Group, to furnish information concerning my child's dental treatments and I hereby assign to Santa Maria Pediatric Dental Group all payments for dental services rendered to my dependent. **I understand that I am financially responsible for this account regardless of any dental coverage**.

Parent signature:_____Date:_____

Print Name:_____

HIPAA PRIVACY OF INFORMATION ACT NOTICE (available upon request)
I have been given the opportunity to review the enclosed HIPAA Privacy Act Notice

☐ **Yes, I want a copy of the HIPAA Privacy Act Notice (or)** ☐ **No, I do not need a copy**

Parent signature:_____Date:_____

DENTAL MATERIALS FACT SHEET ACKNOWLEDGEMENT (available upon request) I have been provided an opportunity to review the *Dental Board of California Dental Materials Fact Sheet* as required by law

Parent signature:_____Date:_____