Welcome to Skyline Pediatric Dentistry!

Reason for today's visit: _____

How does your child feel about today's appointment?

Additional comments/tips:

_____

_____

_____

_____

_____

_____

Health Information

Patient Name: _____ Preferred Name: _____ Today's Date: _____
Last First MI
Birth Date: _____ Age: _____ Social Security #: _____ ☐ Male ☐ Female

Weight:_____lbs Heigth: _____feet _____inches Names of siblings: _____

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

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

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

Please 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 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: _____

Responsible Party Information

Name: _____ Preferred Name: _____ ☐ Married ☐ Single ☐ Other
(or MOTHER) Last First MI

Relationship to patient: _____ Patient Name: _____

Social Security #: _____ Birth Date: _____ Driver's License #_____ State: _____

Phone (Cell): _____ (Work): _____ (Home): _____ Best time to call: AM PM

Address: _____
Street Apartment #

_____
City State Zip Code

E-mail address: _____

Employer Information:_____
Name Street City State Zip Code

Occupation: _____ Employer phone #_____

Name: _____ Preferred Name: _____ ☐ Married ☐ Single ☐ Other
(or FATHER) Last First MI

Relationship to patient: _____ Patient Name: _____

Social Security #: _____ Birth Date: _____ Driver's License #_____ State: _____

Phone (Cell): _____ (Work): _____ (Home): _____ Best time to call: AM PM

E-mail address: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Information:_____
Name Street City State Zip Code

Occupation: _____ Employers phone #_____

Insurance Information

Primary Insurance Company: _____ ID#_____ Group #_____

Mailing Address _____ Phone #_____

Subscriber Name: _____ Date of birth: _____
Last First MI

Secondary Insurance Company: _____ ID#_____ Group #_____

Mailing Address _____ Phone #_____

Subscriber Name: _____ Date of birth: _____
Last First MI

Referral Information

Whom may we thank for referring you to our practice? Person/officename_____

☐ Another patient, friend ☐ Another patient, relative ☐ Dental Office ☐ Online search ☐ School ☐ Work ☐ Insurance website

☐ Other_____

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 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 dental instruments.

We make every effort to maintain the cooperation of young patients using warmth, humor, friendliness, persuasion, gentleness, love, and positive reinforcement. We find one-on-one communication to be most effective in gaining rapport and trust with your child. Therefore, we ask that you allow your child to come into their appointment room without you. There are occasions where additional behavior management may be required to gain cooperation and prevent children from injuring themselves or dental staff. The following is a list of the behavior management techniques that are recommended by the American Academy of Pediatric Dentistry:

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. The procedure is then 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 that is desirable. Examples of rewards include compliments, encouragement, praises, or prizes.

Voice Control: The attention of a disruptive child is gained through lowering or raising the tone and volume of the dentist's voice. Care is taken not to make the child feel threatened. Content of the conversation is less important than the way it is communicated.

Mouth Props a.k.a. "tooth pillow": A soft, rubber device used to assist the child in keeping their mouth open during a procedure and prevent their jaw from getting tired. This can also prevent accidental injury to the dentist's fingers.

Protective Stabilization - Only used if absolutely necessary. The dentist/assistant gently protects the child from movement by holding the child's hands, stabilizing the child's head or positioning the child safely in the dental chair.

Pedi-Wraps/Sedation – These are specific techniques that **will not be used** in this office without further discussion, explanation, separate verbal and written consent from a parent/guardian, and another dental appointment.

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

Skyline Pediatric Dentistry Office Policies

Parents present in the treatment areas:
Research has repeatedly shown that children under the age of three may experience some stranger anxiety and therefore it is best if they are accompanied by a family member. Children **age three and older**, 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. If your child is age three or older and does not have any special healthcare needs, we will request that you kindly remain in our waiting room while we perform your child's routine dental cleanings, exams, and any necessary operative work. We will treat your child the way we would like our own children to be treated by other health professionals. 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 Skyline Pediatric Dentistry. You agree to inform the appropriate staff of Skyline Pediatric Dentistry of any changes in the financial arrangements prior to treatment.

_____	_____	_____
Signature of guarantor of payment/responsible party	Date	Relationship to Patient

Confidentiality Policy

I have read and agree with the notice of Privacy Practices for Skyline Pediatric Dentistry (HIPPA form).

I understand that my healthcare information is protected. I understand that, in order for a member of the Skyline Pediatric Dental Team to leave detailed messages containing specific dental information on my voicemail or answering machine, I need to give permission for them to do so.

Consent for Shared Information with Family & Friends

Under the HIPPA Privacy Law Skyline Pediatric Dentistry is permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I (the undersigned) understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for Dr. Nicholas Woodward and his representatives at our clinic to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my child's care or relevant payment.

	Name	Relationship to patient	Birth Date	Phone Number
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____ _____ _____

Signature of parent or legal guardian | Date | Relationship to Patient