

Welcome to Our Practice!

About Your Child

Patient's Name _____

Preferred Name _____

Date of Birth _____ Male Female

Who is bringing the child today? _____

Who will be financially responsible for this account? _____

What are your goals for your child today? _____

How did you hear about our office?

- | | |
|---|--|
| <input type="radio"/> Friend(Name) _____ | <input type="radio"/> Other Dentist (Name) _____ |
| <input type="radio"/> Drive-By | <input type="radio"/> Pediatrician (Name) _____ |
| <input type="radio"/> Tooth Fairy School Presentation | <input type="radio"/> Insurance Referral |
| <input type="radio"/> Tooth Fairy Event or Fair | <input type="radio"/> Our Website |
| <input type="radio"/> Google or other search engine | <input type="radio"/> Bill-Board |
| <input type="radio"/> Other _____ | <input type="radio"/> Sibling is a Patient already |

Medical History

Has your child ever had any of the following conditions?

- | Y | N | | Y | N | |
|-----------------------|-----------------------|--|-----------------------|-----------------------|--|
| <input type="radio"/> | <input type="radio"/> | Sickle Cell Anemia or Trait | <input type="radio"/> | <input type="radio"/> | Eye Problem (right or left) |
| <input type="radio"/> | <input type="radio"/> | Bleeding Disorder or Hemophilia | <input type="radio"/> | <input type="radio"/> | Hearing Impairment (right, left or both) |
| <input type="radio"/> | <input type="radio"/> | Heart Condition(current or repaired) | <input type="radio"/> | <input type="radio"/> | Immunologic Disorder, HIV, AIDS or ARC |
| <input type="radio"/> | <input type="radio"/> | Heart Murmur (<i>Innocent or Pathological</i>) | <input type="radio"/> | <input type="radio"/> | Kidney Disease or Transplant |
| <input type="radio"/> | <input type="radio"/> | Tetralogy of Fallot | <input type="radio"/> | <input type="radio"/> | Liver Disease or Transplant |
| <input type="radio"/> | <input type="radio"/> | Rheumatic Fever or Scarlet Fever | <input type="radio"/> | <input type="radio"/> | Implanted Shunts, Pins, Screws or Rods |
| <input type="radio"/> | <input type="radio"/> | Bruises or Bleeds easily | <input type="radio"/> | <input type="radio"/> | Cancer, Malignancy, Leukemia or Lymphoma |
| <input type="radio"/> | <input type="radio"/> | Asthma or Lung Problems | <input type="radio"/> | <input type="radio"/> | Physical or Emotional Abuse |
| <input type="radio"/> | <input type="radio"/> | Pneumonia (when? _____) | <input type="radio"/> | <input type="radio"/> | Cleft Lip/Palate |
| <input type="radio"/> | <input type="radio"/> | Diabetes (<i>NIDDM or IDDM</i> _____ x day) | <input type="radio"/> | <input type="radio"/> | Learning Disability |
| <input type="radio"/> | <input type="radio"/> | Seizures, Epilepsy or Convulsions | <input type="radio"/> | <input type="radio"/> | Congenital Birth Defects/Syndrome |
| <input type="radio"/> | <input type="radio"/> | Emotional or Behavioral Problems | <input type="radio"/> | <input type="radio"/> | Tuberculosis or Previous Positive Test |
| <input type="radio"/> | <input type="radio"/> | Diagnosed with ADD, ADHD or Hyperactivity | <input type="radio"/> | <input type="radio"/> | Delayed Development (<i>Approx age child functions</i> _____) |
| <input type="radio"/> | <input type="radio"/> | Psychiatric Problems | <input type="radio"/> | <input type="radio"/> | Cerebral Palsy |
| <input type="radio"/> | <input type="radio"/> | Down's Syndrome | <input type="radio"/> | <input type="radio"/> | Does your child require Antibiotic Pre-medication for dental work? |
| <input type="radio"/> | <input type="radio"/> | Autistic Spectrum Disorder | <input type="radio"/> | <input type="radio"/> | Is there a chance that your child is PREGNANT? |
| <input type="radio"/> | <input type="radio"/> | Latex Allergy or Sensitivity | | | |

Medical History Continued...

Please list any **PAST** or **CURRENT** medical conditions that may affect your child's treatment:

Is the patient currently taking any medication(s)? Yes No Please

list _____

Is the patient currently under the care of a physician? Yes No If so, for

what? _____

Is your child allergic or has your child ever had an adverse reaction to a specific medication, antibiotic or food? Yes No

If so, which one? _____ What happened when he/she took it?

Please list the names & phone number of any treating physicians below:

Type of Physician	Doctor's Name	Office Phone Number

Dental History

Has your child ever suffered from any of the following dental problems?

- | | | | | | |
|-----------------------|-----------------------|------------------------------|-----------------------|-----------------------|---|
| Y | N | | Y | N | |
| <input type="radio"/> | <input type="radio"/> | Bad Breath / Halitosis | <input type="radio"/> | <input type="radio"/> | Popping or Soreness of Jaws (Right, Left or Both) |
| <input type="radio"/> | <input type="radio"/> | Bleeding Gums | <input type="radio"/> | <input type="radio"/> | Dental Infection or Abscess |
| <input type="radio"/> | <input type="radio"/> | Stained or Discolored Teeth | <input type="radio"/> | <input type="radio"/> | Pain from Teeth |
| <input type="radio"/> | <input type="radio"/> | Cold Sores or Fever Blisters | <input type="radio"/> | <input type="radio"/> | Missing or Extra Teeth |
| <input type="radio"/> | <input type="radio"/> | Dry Mouth | <input type="radio"/> | <input type="radio"/> | Injury or Trauma to Teeth, Mouth or Face |

Has your child expressed any dental anxiety or fear? Yes No _____

Has your child had any bad experiences at another dental office? _____

How would you describe your child's current oral health? Excellent Good Fair Poor

What are your primary concerns about your child's oral health? _____

I AGREE THAT ALL OF THE ABOVE MEDICAL HISTORY INFORMATION IS ACCURATE AND CORRECT

* _____
Parent/Guardian Signature

* _____
Date

Person(s) Responsible for Account

Mother's Information: Mother Step Mother Foster Mother Legal Guardian Grandmother

Name:	Date of Birth:	Occupation:
Address:	Social Security #	Employer:
City, State, Zip:	Marital Status:	For how long?
Home Phone:	Cell/Mobile Phone:	Work Phone:

Father's Information: Father Step Father Foster Father Legal Guardian Grandfather

Name:	Date of Birth:	Occupation:
Address:	Social Security #	Employer:
City, State, Zip:	Marital Status:	For how long?
Home Phone:	Cell/Mobile Phone:	Work Phone:

Medical/Dental Release Statement

I give my consent for Dr. Allen Pearson of Children's Dentistry & Orthodontics to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Children's Dentistry & Orthodontics of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Dr. Pearson and his staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

Requirement for Filing Insurance Claims. To precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 30-days of treatment. I hereby authorize payment of insurance benefits directly to Children's Dentistry & Orthodontics. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

* _____
Parent/Guardian Signature

* _____
Date

Financial Agreement

We appreciate you choosing our office for your child's dental care. At Paris Children's Dentistry, we value our relationship with your family and would like to offer the following as our payment policy.

- If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of Wylie Children's Dentistry.
- In case of insurance, we will be happy to help you receive the maximum benefits available under your policy. As a courtesy, we will file your insurance benefits for you after every visit. However, please realize that the relationship is between you, the insured, and your insurance company. If we do not receive payment from your insurance company within 60 days after submission of claim, you will be expected to pay for all dental services in full. In the event of duplicate payments, your account will be reimbursed.
- Once the treatment plan and estimated insurance benefits are reviewed with you, we ask that you pay your portion in full at the time of service.
- Please note that parents or guardians bringing the child into the office on the day of the service will be expected to pay for services rendered.

I have read and understand the payment policies for the office:

* _____
Parent/Guardian Name(**printed**)

* _____
Parent's/Guardian's Signature

* _____
Date

PARENTAL GUIDELINES

Dear Parents,

We want you and your child to receive the best possible treatment at our office. We feel this is a joint process in which the parents will play a pivotal role.

The dental treatment area serves multiple functions. We would like to clarify what the treatment areas are used for and how you can maximize the outcome for your child.

Dental offices perform both non-invasive and invasive procedures at the same time in the treatment area. Your child's regular check-ups are considered non-invasive, while dental surgery and operative are considered invasive.

As a parent we know how much time you've spent in your child's physicians office and we, as dentists, share some similarities with them, most notably seeing several patients throughout the day for non-invasive procedures. The most notable difference is that a physician will perform his invasive surgeries in an outpatient setting or a hospital where only staff and doctors are present. A dentist performs his surgical and operative procedures in the same area and at the same time our non-invasive patients are seen. The dentist requires the same level of concentration given the physician in his controlled environment. Minimum movement and distractions in and about the operative area are crucial for optimum care of the children.

You may choose whether or not to accompany your child to his/her filling appointment. Although we sense some children do better without parents present, we are open to having you present with your child. If you choose to be present, we suggest the following **guidelines** to improve chances of a positive outcome:

You can assist us by following a few guidelines:

1. Allow us to prepare your child
2. We welcome you to come back to the Treatment Area for your child's **FIRST** visit. On following visits and for all restorative visits, we ask that you allow one of our staff members to stay with your child throughout their entire visit. Unless we make prior arrangements with you, we ask that you wait for your child in our reception area until they are finished with their treatment.
3. Be supportive of the practice's terminology
4. Please be a **SILENT OBSERVER**. That means no talking during dental procedures. Support your child with touches
 - a. This allows us to maintain communication with your child
 - b. Children will normally listen to their parents instead of us and may not hear our guidance
 - c. You might give incorrect or misleading information
5. If asked to leave, be ready to immediately walk away
 - a. Many children will try to **control** the situation
 - b. "Acting out" is normal, but unacceptable during fillings
 - c. This is intended to "short circuit" the control attempt
 - d. We will continue to support your child at all times

Additional siblings over the age of two in the treatment room present the potential for future dental anxiety to themselves due to possible misinterpretation from a child's perspective.

Following these few simple guidelines will help to insure the best possible results.

I have read the above information and have been explained the office policy on parental presence in the treatment area.

Parent/Guardian

DATE

Witness

DATE

Why We Do Not Offer Silver Amalgam Fillings

Silver fillings have been the primary choice for routine use due to ease of use and their relatively low cost. Silver fillings do have a down side however. They are held in place by mechanical undercuts that are purposely made in the tooth to hold the filling in place. These undercuts are wedge shaped and weaken the tooth significantly. This wedging effect is analogous to a wedge used to split logs. Well, guess what? This same wedging effect occurs in the tooth: the silver filling being the wedge and the tooth being the log. You may bite into something, and without warning, the tooth splits. Now you need a crown, a root canal, a build up, or all three. Worse yet, the tooth may split in a location and a manner that would require that it be extracted.

Here's the good news! The revolutionary new bonded, tooth colored fillings make the tooth stronger, much less likely to crack and fracture, and also get ride of all those "black" silver fillings in your mouth. Instead of placing wedge-shaped undercuts in your tooth to hold the filling in, I drill a bowl-shaped design with no sharp edges or undercuts. This alone makes the tooth much less likely to fracture. In addition to this, the white fillings are chemically bonded to the tooth, which reduces the chances of fracture even further.

Now, unfortunately, here's the bad news. Insurance companies HATE these white fillings! Why? Because they cost more. Why do they cost more? First of all, the white fillings material costs two to four times as much as an equivalent amount of silver filling material, and it takes more time and more skill to place the white fillings correctly. Since you have chosen me to provide your dental care, I feel that it is my obligation to provide you with the best service possible, and also to use the best materials and techniques that modern dentistry has to offer.

Forget all of the advantages that this treatment provides. Forget that it leads to a healthier tooth and a great looking mouth. Most insurance companies won't cover the bonded, tooth colored fillings, and will only pay what they would have paid for the cheaper silver fillings. Unfortunately, that means that there is a larger balance due from you. We are hopeful that insurance companies will one day come out of the "dark ages" and into the 21st century, but don't count on it happening soon!

Let's face it, insurance companies are making enormous profits off the backs of their policy holders, which is you, the patient. In 1994, United Health Care's CEO was paid \$61,200,000. (Sixty one point two MILLION DOLLARS!) This equates to 1.17 million per week, or \$235,384.62 per day, or \$29,423.08 per hour). The contracts that insurance companies have with their subscribers obligate them to pay only for the "minimally acceptable treatment." This means that you get the bottom of the barrel. In the eyes of the insurance companies, silver fillings are "good enough." In my personal and professional opinion, "good enough" IS NOT good enough! Only the best is truly "good enough".

I hope that this has explained my position regarding placement of white fillings instead of silver fillings. I am very excited that I can provide you with healthier fillings for your teeth that are nearly invisible! As always, please feel free to discuss your treatment with me. Remember, it's your mouth. The choice belongs to you, NOT to your insurance company!

Sincerely, Dr. Allen Pearson

I have read the above and agreed to be personally responsible for the monies owed toward any white fillings that I or any other persons for whom I am financially responsible might need for which my insurance company refuses to pay.

Parent/Guardian Signature: * _____

HIPPA Consent Agreement(Privacy Act)

You may refuse to sign this agreement

I give consent for the Use and Disclosure of Health Information of myself and or my dependant for the purpose of Treatment, Payment, or Communication between other healthcare professionals.

I understand and have been provided with a copy of this office's Notice of Privacy Practices that provides a more complete description of health information uses and disclosures.

I understand that I have the right to review a copy of this office's Notice of Privacy Practices prior to signing this condensed form.

* _____

Please Print Name

* _____

Signature of Parent or Guardian

* _____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other(Please specify) _____

Date: _____ Doctor's Signature _____