POLKADOT
PEDIATRIC DENTISTRY

HOW TO PREPARE YOURSELF AND YOUR CHILD BEFORE YOUR CHILD'S APPOINTMENT

We highly recommend parents to keep any negative experiences or comments to themselves and let your child enjoy their first dental visit with the same enthusiasm as a visit to the toy store! But remember, since most children do not know what to expect, it is very normal for a young child to cry or be slightly anxious.

Some reasons why some children have dental anxiety:

1. **Young age.**
2. Previous bad experience.
3. Recent vaccine or medical procedure at pediatrician office.
4. Parents mention their bad dental experiences to their children and talk about how much they dislike going to the dentist. Therefore, the child believes the dentist is a "bad" place and has a negative view of the dentist. **Always be positive!** Allow them to make their own observations and judgment of the dental appointment.
5. Unsure of what is going to happen. This is why we try to explain every step, instrument and supply in kid friendly terms, the best we can. Please allow the dental team to describe the steps that will go on in today's visit. **You may give incorrect or misleading information.**
6. A person in the child's family or group of friend's mention that they were going to receive a "shot." **NEVER EVER USE THAT TERM!!!!**

Examples of Kid Friendly Terms:

1. Dental Cleaning = "Tickle Teeth" or "Wash Teeth" or "Teeth are going to get a wash like a car wash."
2. Dental Extraction = "Wiggle Teeth"
3. Dental Injection = "Give your tooth some sleepy juice so it can take a nap and the sugar bugs can take a nap."
4. Dental Drill = "Water Whistle" or "Scrub your teeth"
5. Dental Suction = "Mr. Thirsty"

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Medical Dental History Form

PATIENT INFORMATION

Date:_____

Child's Last name: _____ First name: _____ Middle initial: _____

Preferred Name: _____

Date of Birth: _____ Sex: Male ☐ Female ☐ Social Security #: _____ - ____ - _____

School: _____ Grade: _____ E-mail address: _____

Home address: _____ City: _____ State: _____ Zip code: _____

Home phone: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

Hobbies:_____

How would you prefer us to contact you regarding notice of upcoming appointments?

☐ Email ☐Text ☐Cell ☐Home Phone

Whom may we thank for referring you to our practice?_____

PARENT/GUARDIAN INFORMATION

☐Mother ☐Stepmother ☐Grandparent(s) ☐Other Guardian Name: _____

SSN: _____ Birth date: _____Email address: _____

Address (*if different than patient address)* _____

Home phone (*if different):* (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

Employer:_____

☐Father ☐Stepfather ☐Grandparent(s) ☐Other Guardian Name: _____

SSN: _____ Birth date: _____Email address: _____

Address (*if different than patient address)* _____

Home phone (*if different)*: (_____)_____ Cell phone: (_____)_____ Work phone: (_____)_____

Employer:_____

DENTAL INSURANCE

Primary Policy Holder's full name: _____ Relationship to patient: _____

Policy Holder SSN#_____ Date of Birth: _____

Employer: _____ Address: _____

Insurance company _____ Group#: _____ ID#: _____

Secondary Policy Holder's full name: _____Relationship to patient _____

Policy Holder SSN#: _____Date of Birth:_____

Employer: _____ Address: _____

Insurance company: _____ Group#: _____ ID#: _____

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Your answers are for office records only, and are confidential.

DENTAL HISTORY

Last Dental Visit: _____ *Last Cleaning:*_____

Previous Dentist:_____ Do you have a copy of previous x-rays? ☐Yes ☐No

Reason for today's visit: ☐Exam and Cleaning ☐Emergency ☐Consultation

My child brushes his/her teeth _____ times a day.

Do you ever help brush his/her teeth? ☐Always ☐Sometimes ☐Never

Does your child floss every day? ☐Yes ☐No Is fluoride taken in any form? ☐Yes ☐No

Is there a history of bad dental experience? ☐ Yes ☐No Please explain:_____

Do you expect your child to be cooperative? ☐Yes ☐No

Is your child in pain today? ☐Yes ☐No Please explain:_____

Does your child have any mouth habits? (Please circle all that apply)

Thumb/Finger Sucking Grinding during sleep Pacifier Sleeping with bottle Other:_____

Any history of injuries to mouth/teeth?_____

Any sensitive or sore teeth?_____

Does your child snore or breath with their mouth while sleeping?_____

Are you on well water?_____

Do you have any concerns about your child's teeth?_____

PHYSICIAN

Child's Physician _____ Address:_____Phone#_____

Date of last physical exam: _____ Reason:_____

Other physicians/health care providers being seen now:

Name _____City _____ State _____

Reason _____

Name _____City _____ State _____

Reason _____

MEDICAL HISTORY

Does your child take any medications? ☐ Yes ☐No

If yes, please list medications and include dosage (including supplements and herbals:_____

_____

Are immunizations up-to-date? ☐Yes ☐No

Has your child been treated in an emergency room? ☐Yes ☐No

If yes, please explain:_____

Has your child been hospitalized? ☐Yes ☐No

If yes, please explain:_____

Any handicaps/disabilities? ☐Yes ☐No

If yes, please list:_____

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Indicate which of the conditions your child has now or ever has had:

ADD/ADHD	☐**yes**	☐**no**	Heart Murmur	☐**yes**	☐**no**
AIDS/HIV	☐**yes**	☐**no**	Heart Valve Replacement	☐**yes**	☐**no**
Anemia	☐**yes**	☐**no**	Hepatitis A B C (circle)	☐**yes**	☐**no**
Arthritis or joint problems	☐**yes**	☐**no**	Hemophilia	☐**yes**	☐**no**
Asthma	☐**yes**	☐**no**	Immune Deficiency Disease	☐**yes**	☐**no**
Autism	☐**yes**	☐**no**	Kidney Disease	☐**yes**	☐**no**
Birth defects or hereditary problems	☐**yes**	☐**no**	Learning Disability	☐**yes**	☐**no**
Bladder Issues	☐**yes**	☐**no**	Measles/ Mumps	☐**yes**	☐**no**
Bleeding Issues	☐**yes**	☐**no**	Mononucleosis	☐**yes**	☐**no**
Bone Disease	☐**yes**	☐**no**	Neurological Disorder	☐**yes**	☐**no**
Brain Injury	☐**yes**	☐**no**	Psychiatric/ Psychological Disorder	☐**yes**	☐**no**
Bruising Issues	☐**yes**	☐**no**	Reflux	☐**yes**	☐**no**
Cancer/tumors	☐**yes**	☐**no**	Rheumatic/ Scarlet Fever	☐**yes**	☐**no**
Chemotherapy/Radiation	☐**yes**	☐**no**	Seizures/ Epilepsy	☐**yes**	☐**no**
Cerebral Palsy	☐**yes**	☐**no**	Fainting	☐**yes**	☐**no**
Diabetes or low sugar	☐**yes**	☐**no**	Sickle Cell	☐**yes**	☐**no**
Handicaps/ Disabilities	☐**yes**	☐**no**	Skin Disorder	☐**yes**	☐**no**
Hearing Loss	☐**yes**	☐**no**	Speech Disorder	☐**yes**	☐**no**
Headaches	☐**yes**	☐**no**	Thyroid Disease	☐**yes**	☐**no**
Congenital Heart Disease	☐**yes**	☐**no**	Tonsillitis	☐**yes**	☐**no**
Heart Defects	☐**yes**	☐**no**	Other:		_____
			_____		

ALLERGIES

Has your child had allergies or reactions to any of the following?

☐Latex ☐Penicillin/Amoxicillin ☐Latex ☐Aspirin ☐Ibuprofen (Motrin/Advil)

☐Metal ☐Sulfa ☐Red Dye ☐Foods ☐None

☐Other

RELEASE AND WAIVER

I authorize release of any information regarding my child's dental treatment to my dental insurance company.

Parent/Guardian Signature _____ Date _____

I have read the above questions and understand them. I will not hold my pediatric dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my pediatric dentist of any changes in my child's medical or dental health.

Parent/Guardian Signature _____ Date _____

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NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

• Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third party payers.
• Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understand your *Notice Of Privacy Practices* containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its *Notice Of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice Of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or is closed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

_____
Patient Name

_____
Relationship to Patient

_____
Signature

_____
Date

Staff Member Sign:_____

OFFICE USE ONLY:

I attempted to obtain the patient's signature in acknowledgement on this *Notice of Privacy Practices.* Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____