PEDIATRIC DENTISTRY CONSENT FOR DENTAL PROCEDURES
AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, extractions, etc., will be performed at a separate appointment after obtaining your permission.

State law requires that we obtain your written informed consent for any treatment given to your child as a legal minor.

1. I hereby authorize and direct the doctors of Austin Children’s Dentistry assisted by dental auxiliaries of his or her choice, to perform upon my child the following dental treatments or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2. In general terms the dental procedures or operation may include:
   A. Cleaning of the teeth and the application of topical fluoride.
   B. Application of plastic “sealants” to the grooves of the teeth.
   C. Treatment of the diseased or injured teeth with dental restoration (fillings or caps)
   D. Replacement of missing teeth with dental prosthesis.
   E. Treatment of malposed (crooked) teeth and or oral developmental or growth abnormalities.
   F. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts for 1 1/2 to 3 hours.
      Allergic reactions are rare and your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child they are going to get a “shot”, we have a special way of informing them of this that prevents fear.
   G. Use of nitrous oxide (laughing gas) may be used to help children relax and feel the injection less. This gas is placed over your child’s nose after an explanation is given. This gas is very safe when used in the concentration that will be used, and the nose piece, as with all treatment, will not be forced upon your child.
   H. Use of behavior management techniques outlined on page 2.

I fully understand there is a possibility of surgical and or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize the doctors of Austin Children’s Dentistry to perform treatment as may be advisable to preserve the health and life of my child.

I further understand that parents may be asked to remain in the reception area if needed for behavior management or for the benefit of the success of the treatment.

I hereby state that I have read and understand this consent and the behavior management techniques on page 2 and that all questions about the procedures have been answered in a satisfactory manner. I also understand that I have a right to be provided with answers to questions which may arise during the course of my child’s treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

DATE:__________________________________________ TIME:____________________ am/pm

PATIENT:_________________________________ SIGNATURE OF PARENT OR GUARDIAN:_____________________

RELATIONSHIP TO PATIENT:____________________ WITNESS:_________________________________________
BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental clinic be the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, due to 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 open for long enough to perform the necessary dental treatment. Also, aggressive or physical resistance such as kicking, screaming, grabbing the dentists hands or sharp instruments can prevent the proper treatment being preformed.

All efforts will be used to obtain the cooperation of the adolescent patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of adolescent patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. Tell-show-do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition. Then the dentist or assistant shows the child what is to be done by demonstrating 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

2. Positive reinforcement: This technique rewards the child who displays any behavior that is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.

3. Voice control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist’s voice. Content of the conversation is less important than the abrupt or sudden nature of a command.

4. Mouth props: A rubber or plastic device is placed in the child’s mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.

5. Sedations: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or is unable to comprehend or cooperate for dental procedures. These drugs may be administered orally, by injection or as a gas (nitrous oxide and oxygen). The child does not become unconscious. You child will not be sedated without you being further informed and obtaining your specific consent for such a procedure.

6. General anesthesia: The dentist performs the dental treatment with the child anesthetized in a hospital operating room. Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for such a procedure.

INITIALS:_________DATE:________________
FINANCIAL POLICY

INSURANCE BENEFITS

I understand it is my responsibility to inform and update this office of any changes in dental insurance coverage and also update any changes in address or contact phone numbers. I understand that this office requires 24 hours notice in order to verify my child’s coverage. If adequate notice is not given, I am aware that it is my responsibility to reschedule my child’s dental appointment or pay the full fee of the visit.

UNPAID INSURANCE BENEFITS

All dental services provided, whether the patient has dental insurance or not, are charged directly to the financially responsible party and that he or she is personally responsible for payment of all dental services. If the insurance company has not paid a claim after 60 days of being submitted, this office will require the patient to pay the account balance unless other arrangements have been made. It is your responsibility to know your plan and its limitations including but not limited to your deductible, plan maximum and coverage details.

TREATMENT ESTIMATES

Austin Children’s Dentistry routinely provides our patients with an estimate of cost for the purposed treatment. Since your insurance determines the benefit payable for services, this office can not be held responsible for 100% accuracy on what is only an estimate for treatment. This office provides only an estimate based on your insurance coverage. All insurance companies provide a disclaimer when insurance benefits are being quoted:

“Information is subject to change. Benefits described are not a guarantee of payment. Actual benefits payments are determined only when a claim is received, eligibility is not a guarantee of coverage.”

COLLECTION ACCOUNTS

If an account is turned over to a collection agency and or attorney for collection, the account holder will be responsible for all attorney and collection fees. Any account that is 90 days past due is subject to being sent to collections. Unless other arrangements have been made.

I hereby verify with my signature below that I have read and understood the office policies stated above and also grant Austin Children’s Dentistry and or affiliates permission to contact me in matters related to this form.

PATIENT NAME:______________________________________

SIGNATURE OF PARENT OR GUARDIAN:___________________________________________________________

WITNESS:___________________________________________________________DATE:____________________
Date: __________________________

In my absence, I hereby give authorization for the person(s) listed below to bring my child(ren) to Austin Children’s Dentistry and to consent for any and all recommended dental/mediacl services.

Legal guardian must bring child to first dental appointment.

<table>
<thead>
<tr>
<th>Child(ren) names and date of birth:</th>
<th>Authorized person(s)/Relationship to child(ren)</th>
</tr>
</thead>
<tbody>
<tr>
<td>_______________________________</td>
<td>________________________________</td>
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<td>_______________________________</td>
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<tr>
<td>_______________________________</td>
<td>________________________________</td>
</tr>
</tbody>
</table>

Parent/Legal Guardian signature: ______________________________________________________

Printed name: ____________________________________________________________

This authorization will remain in effect until changes are made by the parent/guardian as signed above.

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Minor Children (ages 15, 16, and 17 only)

My child(ren), ________________________________ may be seen for dental attention in the office of Austin Children’s Dentistry WITHOUT a parent or legal guardian present.

Parent/Legal Guardian: __________________________________________________________

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Adults (ages 18 years or older-ONLY)

I give my consent for the listed person(s) below to have any and all access to my dental records on file with Austin Children’s Dentistry.

Adult Signature: __________________________________________________________

Information may be shared with:______________________________________________
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES

**You may refuse to sign this acknowledgement**

I, __________________________________________ have received a copy of this office’s Notice of Privacy Practices.

PRINT NAME:________________________________________ __________________________________

SIGNATURE:_________________________________________ __________________________________

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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (please Specify):

_________________________________________________ ___________________

_________________________________________________ ___________________

_________________________________________________ ___________________
To help us meet all of your child’s dental needs please fill out this form **completely and accurately.**

**PATIENT INFORMATION**

Name:___________________________________________ Birthdate:_________________ Age:_______________ Male/Female
Address:___________________________________________ City:_____________________ State:_______ Zip:_________
Home Telephone #:__________________________________ Alt. #______________________________________

Do we see siblings? Yes/No If so, their names?__________________________________________________________

**Whom may we thank for referring you to our office?**

**PARENT OR GUARDIAN**

e-mail:________________________________

Father’s name:_____________________________________ Relationship: __________________________ Birthdate:__________
Employer:__________________________________________ SS#_______________________________
Home Telephone #:_______________________________ Cell:___________________________ Work:___________________________

Mother’s Name:_____________________________________ Relationship: __________________________ Birthdate:__________
Employer:__________________________________________ SS#_______________________________
Home Telephone #:_______________________________ Cell:___________________________ Work:___________________________

**INSURANCE INFORMATION**

As a **courtesy** we accept assignment of benefits from most insurance companies. In order to do so, you must provide us with the following information:

Policy Owner:______________________________________ Relationship to patient:___________________________

Insured’s SS#______________________________________ Birthdate:__________ Employer:___________________________

Insurance Company:_________________________________ Phone #:____________________________________

Group name:______________________________ Group #:_______________________________ Address:___________________________

**DENTAL HISTORY**

Why is your child here today?__________________________________________________________

Is this your child’s first dental visit? Yes/No If no, when was the last dental visit?__________________________

How do you expect your child to behave today? Circle all that apply. Friendly / Happy / Anxious / Timid / Afraid / Resistant

Does your child receive fluoride in any form? Yes/No. If so, in what form?__________________________

Has your child inherited any dental characteristics?________________________________________________

Have there been any injuries to your child’s teeth?________________________________________________

Please circle if your child has had any of the following problems or oral habits? Cavities / Toothache / Bad Breath / Crooked teeth / Sensitive to sweets / Bleeding gums / Sensitive to hot or cold / Frequent headaches / Discolored teeth / Loose teeth / Teeth bumped / Thumb sucking / Pacifier use / Lip biting / Teeth grinding / Other:________________________________________________

How often does your child Brush?________ Floss?________ At what age did your child stop using a bottle?_______

Sippy cup?________________________________________
MEDICAL HISTORY

Child’s physician: ___________________________________________ Phone # ____________________________

Is your child in good general health? Yes/No. If no please describe: __________________________________________

Where there any problems at birth? Yes/No. If yes please describe: ______________________________________

Are your child’s immunization and booster shots all up to date? Yes/No. Any drug or food allergies? Yes/No. If so please list and describe the type of reaction. ___________________________________________________

Has your child had any surgical operations? Yes/No. If so, please describe: ________________________________

Has your child ever been hospitalized? Yes/No. If yes, please explain: ____________________________________

Please circle yes or no for any of the following conditions your child has had or now has.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>Y / N</td>
</tr>
<tr>
<td>Asthma</td>
<td>Y / N</td>
</tr>
<tr>
<td>Heart trouble</td>
<td>Y / N</td>
</tr>
<tr>
<td>Heart Murmur</td>
<td>Y / N</td>
</tr>
<tr>
<td>Rheumatic fever</td>
<td>Y / N</td>
</tr>
<tr>
<td>Blood disease</td>
<td>Y / N</td>
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<tr>
<td>Anemia</td>
<td>Y / N</td>
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<tr>
<td>AIDS virus</td>
<td>Y / N</td>
</tr>
<tr>
<td>Diabetes</td>
<td>Y / N</td>
</tr>
<tr>
<td>Ear/eye/nose/throat problem</td>
<td>Y / N</td>
</tr>
<tr>
<td>Thyroid disease</td>
<td>Y / N</td>
</tr>
<tr>
<td>Any other condition?</td>
<td>Y / N</td>
</tr>
</tbody>
</table>

CURRANT MEDICATIONS

Name/strength    How often?    Reason taken?
___________________________________________________ ___________________________________________________
___________________________________________________ ___________________________________________________
___________________________________________________ ___________________________________________________

SOCIAL HISTORY

Circle if your child has any problems with the following? Speech / hearing / vision / sleep  Do you consider your child to be?

Advanced learner / progressing normally / slow learner Your child’s first language? ____________________________

Second language? ____________________________ Is your child adopted? Yes / No. If so at what age? __________

How does your child tolerate medical or dental treatment?

Your child’s favorite things? (Pet, toy, color, friend, hobby etc.) ____________________________

Authorization and release: I understand that a payment of a calculated % is due at the time of treatment, and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by my dental insurance company within 30 days of the date of service. I understand that any unpaid balances may be sent to a collection company and I will be responsible for all collection charges. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child’s health. It is my responsibility to inform this dental office of any changes in my child’s medical status. I authorize this office to release any information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers’ and or other health practitioners.

SIGNATURE OF PARENT OR GUARDIAN: ___________________________________________ DATE: ___________________