Cedar Park Pediatric Dentistry

Dr. Bert Vasut & Dr. Dan Boboia

Dental Care & Orthodontics for Your Children & Teenagers!

2051 Cypress Creek Road, Ste N
Cedar Park, Texas 78613
(512) 258-8888

Patient Information

Child's First Name: _____

Child's Last Name: _____

Nickname: _____ ❒Male ❒Female

Date of Birth ___/____/_____ Child's Age _____

Child's Address: _____

_____

City_____ State_____ Zip_____

Child's Home # (___) _____

Insurance Policy Agreement

Your insurance plan is an agreement between *your insurance company and you*. We file claims to your insurance company as a courtesy to you. After 60 days, any outstanding balance will be your financial responsibility.

Initial: _____ ***Date:*** _____

Father's Information

Name: _____

Please Circle: Father Stepfather Guardian

SSN# _____

Date of Birth:___/____/____ Marital Status:_____

Cell # (_____) _____

Work # (_____) _____

❒ *Check if Address is same as Child*

Address: _____

_____

City_____ State_____ Zip_____

Home # (_____) _____

Primary Insurance

Insurance Co Name:_____

Insurance Co #(_____)_____

Claims Mailing Address:_____

_____

City_____ State_____ Zip_____

Member's Name: _____

Member's Date of Birth _____/_____/_____

Member's ID# _____

Group#_____

Place of Employment_____

Relationship to patient_____

Mother's Information

Name: _____

Please Circle: Mother Stepmother Guardian

SSN# _____

Date of Birth:___/____/____ Marital Status:_____

Cell # (_____) _____

Work # (_____) _____

❒ *Check if Address is same as Child*

Address: _____

_____

City_____ State_____ Zip_____

Home # (_____) _____

Secondary Insurance

Insurance Co Name:_____

Insurance Co #(_____)_____

Claims Mailing Address:_____

_____

City_____ State_____ Zip_____

Member's Name: _____

Member's Date of Birth _____/_____/_____

Member's ID# _____

Group#_____

Place of Employment_____

Relationship to patient_____

Confirming Appointments via Email:

Primary Email: _____

Our system only allows one email to confirm appointments. Please provide us with your preferred email.

Referral Information:

Whom may we thank for referring to our practice?

_____

Dental History

Why is your child here today? _____

_____

Are other children previous patients? _____

Who? _____

Is this your child's first visit to a dentist? _____

If no, date of last dental visit: _____

Is your child adopted? _____

If so, At what age? _____

How does your child tolerate dental/medical care? _____

_____

How will your child behave today? Please check all: ❒ Timid ❒ Happy ❒ Anxious ❒ Friendly ❒ Afraid ❒ Resistant

Any Dental Complaints? _____

_____

Please select any of the following habits your child currently has:

❒ thumb-sucking ❒ lip/nail biting
❒ sleeping w/ bottle ❒ bad breath
❒ pacifier use

Medical History

Child's Physician _____

Address: _____

City_____ State_____ Zip_____

Physician's#(_____) _____

Child's Pharmacy _____

Pharmacy #(_____) _____

Address: _____

Does your child have a Heart Murmur? _____

Please understand that we will need a letter from your Cardiologist stating if your child does or does not require Premed prior to all dental treatment including cleanings.

Please have the child's Cardiologist fax documentation to us at (512) 583-0375.

Any Drug or Food Allergies? _____

*If Yes, please list below*_____

_____

Fluoride History

Does your child brush daily? _____

Does your child floss daily? _____

Does your child receive fluoride? _____

If So, Please select: ❒ Tablets ❒ Drops ❒ Vitamins ❒ Rinse ❒ Toothpaste

Current Medications

Name / Strength (mg) How often? Reason Taken

_____

_____

_____

Please write YES or NO if your child has/does experience any of the following?

Abnormal Bleeding _____	Diabetes/Hypoglycemia _____	Nervous/ Mental Disorders _____
ADHD/ ADD _____	Down's Syndrome _____	Ear/Nose/Eye/Throat Trouble _____
AIDS virus/ HIV _____	Eating Disorders _____	Autism/Asperger's/PDD/NOS _____
Stomach Ulcers _____	Herpes virus/ Shingles _____	Cancer/Tumors/Growths/Cyst _____
Asthma _____	Rheumatic Fever _____	Mumps/ Measles/ Chickenpox _____
Birth Defects _____	Jaundice / Hepatitis _____	Frequent Diarrhea/ Vomiting _____
Blood Transfusions _____	Kidney / Liver Problems _____	High/ Low Blood Pressure _____
Cerebral Palsy _____	Latex Allergy _____	Steroid Therapy/ Chemo _____
Cleft Lip / Palate _____	Scarlet fever/ High fever _____	Hemophilia/ Blood Disease _____
Surgeries _____	Jaw Problems/ TMJ/TMD _____	Convulsions / Seizures _____
Thyroid Disease _____	Tuberculosis/ TB _____	Other _____

**If Yes, Please Specify: _____

_____.

Consent to Treat

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes to my child's medical status.

I also authorize the doctors and the dental staff to perform any necessary dental services my child may need. The responsible party is the parent who brings the child to the dental office, independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. We will not intervene.

Printed Name of Parent/ Guardian: _____

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

Office Billing Policy

Payment is due at the time of service. If insurance is not being filed, payment is due in full. If we are filing insurance, your estimated portion will be collected at the time of service. Payment is accepted in the form of cash, check, debit cards, or credit card (Visa, Master Card, Discover, American Express or Care Credit).

Printed Name of Parent/ Guardian: _____

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

Consent to Use & Disclosure of Health Information
Health Information Privacy Policy Act (HIPPA)

Child's name: _____

In General, the HIPPA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of their home.

I authorize the professional office of Cedar Park Pediatric Dentistry and staff to release health information about me and/or my child under the following terms and conditions:

- **Information for treatment purposes.**
- **To your insurance company (if applicable), pharmacist and to doctors to whom we refer too.**
- **For the reason of obtaining payment from your insurance, to submit a prescription and share our diagnosis and information to doctors whom you are referred.**
- **Confirm or make appointments or discuss other account matters.**
- **I understand school notes <u>will not</u> be faxed to my child's school. I understand I am responsible for any excuses required by my child's school.**

**I understand I have the right to revoke this authorization. If I choose to do so, I will provide the office of Cedar Park Pediatric Dentistry with a written or electronic note stating that my authorization is revoked. The only exception to my right to revoke is if we have already acted in reliance upon the authorization.

I have read and understand this form. I authorize the disclosure of my child's health information as described in this form.

Printed Name of Parent/ Guardian: _____

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

Cedar Park Pediatric Dentistry

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BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental operatories shall 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, 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 and 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 the sharp dental instruments.

All efforts will be made to obtain the cooperation of the child dental 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 child 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 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.

2. Positive reinforcement: This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, 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 the 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. General anesthesia: The dentist performs the dental treatment with the child anesthetized if the child does not respond to other behavior management techniques or is unable to comprehend or cooperate for the dental procedures. Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for such procedure.

Patient's Name: _____

Printed Name of Parent/Guardian: _____

Parent/Guardian
Signature: _____Date:_____

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PEDIATRIC DENTISTRY CONSENT for DENTAL PROCEDURES and ACKNOWLEDGEMENT for 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 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. is only performed 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.

Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain further.

I hereby authorize Dr. Vasut and/or Dr. Boboia assisted by other dental auxiliaries of their choice to perform upon my child the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

In general terms the dental procedures or operations will include:

A. Cleaning of the teeth and application of topical fluoride.
B. Application of plastic "sealants" to the grooves of the teeth.
C. Treatment of diseased or injured teeth with dental restoration (fillings or caps).
D. Replacement of missing teeth with dental prosthesis.
E. Removal (extraction) of one or more teeth.
F. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
G. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1.5-3 hours. Allergic reactions are rare. Your child will be cautioned not to bite the numb lip or cheek. Please do not tell your child that they are going to get a "Shot". We have our special way to inform them of this.

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 Dr. Vasut and/or Dr. Boboia to perform treatment as may be advisable to preserve the health and life of my child.

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; and I 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 chose to terminate it.

Patient's Name: _____

Printed Name of Parent/Guardian: _____

Signature of Parent or Guardian:_____Date:_____