WEST VALLEY
PEDIATRIC
DENTISTRY

Patient Information

Patient Name_____ Date _____
Address_____ City_____ State_____ Zip_____
Home Phone:_____Birth date_____ Age_____ Sex Male Female
Cell Phone:_____ email address:_____ @ _____

Please initial below if you would NOT like to receive appointment reminders via email and/or text:
____I would NOT like to receive email and /or text appointment reminders

Parent/Guardian Information

Father

Full name_____
Date of Birth_____
Home address_____
State_____ Zip_____
Employer_____
SS#_____ DL# _____

Mother

Full name_____
Date of Birth_____
Home address_____
State_____ Zip_____
Employer_____
SS#_____ DL#_____

Name of person financially Responsible fro payment_____
Emergency Contact

Insurance

(Insurance Information must be completed in full if you would like us to bill for services)

Primary

Policy Holder_____
Insurance Company_____
Address_____
City_____ St_____ Zip_____
Phone Number_____
Policy Number _____

Secondary

Policy Holder_____
Insurance Company_____
Address_____
City_____ St_____ Zip_____
Phone Number_____
Policy Number _____

How did you hear about our office?

- Google/Internet
- Friend or Relative (please list who, so that we may thank them!) _____
- Phonebook
- Mailer
- Other:_____

All of the above information is true and correct to the best of my knowledge. If there are any changes to my child's or my information I will inform this office immediately.

_____ _____
Parent/Guardian Date

WEST VALLEY PEDIATRIC DENTISTRY

MEDICAL HISTORY

Patient Name: _____
First Last

Date of Birth: ___ /___ /___

Has your child **ever had or been exposed** to any of the following

HIV	Yes	No
Hepatitis C	Yes	No
Hepatitis B	Yes	No
Tuberculosis	Yes	No

Has your child had or have a history of the following?

Heart Murmur	Yes	No
Rheumatic Fever	Yes	No
Heart Condition	Yes	No
Asthma	Yes	No
Blood Disorder	Yes	No
HIV/Aids	Yes	No
Epilepsy	Yes	No
Joint Replacement	Yes	No
Radiation Treatment	Yes	No
Physical Disability	Yes	No
Mental Disability	Yes	No
ADHD/Hyperactivity	Yes	No
Other	Yes	No
Cancer	Yes	No

Please Explain_____
_____

Medication

List all medications your child is currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies

Does your child have an allergy to any of the following?

Local Anesthetic	Yes	No
Penicillin	Yes	No
Sulfa	Yes	No
Latex	Yes	No

List any other drug allergies your child has:

1. _____
2. _____
3. _____

Name and number of current Physician:

_____

List any Hospitalizations/surgeries your child has had:

1. _____ Month/Year: _____
2. _____ Month/Year: _____
3. _____ Month/Year: _____

CARRIES RISK ASSESSMENT

HOMECARE PRACTICES:

1) **How often does the patient brush his/her teeth?**
twice per day Once per day Less than once per day

2) **How long does the patient brush his/her teeth for?**
less than 2 minutes greater than 2 minutes

3) **How often does the parent watch and supervise brushing?**
Daily Sometimes Never

4) **How often does the patient floss his/her teeth?**
Daily Sometimes Never

DIETARY PRACTICES:

1) **How many healthy meals does the patient eat every day?**
<1 1-2 3

2) **Does the patient have multiple sugary/sweet treats in between meals?**
Yes No

Dr. Initials:_____

FLUORIDE ASSESSMENT:

1) **Does the patient use a fluoride toothpaste?**
Yes No Too young/other

2) **Does the patient have any other DAILY source of fluoride?** (check all that apply)

0 Salt Lake County Tap Water (drinks tap water)
0 Prescription Fluoride Toothpaste
0 Fluoride trays/topical fluoride
0 RX Fluoride Drops/tablets
0 Fluoride mouthwash
0 Other: _____

FOR PATIENTS UNDER 5 YEARS OLD:

3) **Does the patient still drink from a bottle or sippy cup?**
Yes No
If yes, does he/she get put to bed at night with a bottle/sippy cup to help him/her sleep?
Yes No

4) **What is the usual drink that patient has at meal times?** _____

X_____ Date: _____
(Parent/Guardian Signature)

WEST VALLEY
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Patient Name:_____

Informed Consent

I UNDERSTAND that in the dental treatment of CHILDREN, there are possible inherent risks such as, but not limited to the following, including the understanding that no promises or guarantees of results have been made nor are expected.

1. Treating children often presents special problems: Perhaps the most difficult problem is that of controlling the child in order that no injury accidentally occurs as a result of the child making some abrupt or uncontrolled movements during treatment. In some cases it may be advisable to recommend medication to sedate the child prior to treatment. Additionally, various restraining devices may also be necessary to ensure safety of the child patient during treatment.

2. Numbness: There will be numbness in the tongue, lips, teeth, jaws, and/or facial tissues resulting from the administration of local anesthetic that may persist following treatment. During this period of numbness the child should be constantly monitored and reminded to not bite on or chew on the lips or the tongue. If the numbness appears to last longer than 24 hours the office should be notified at once.

3. Dental "Fillings": Decay dissolves the tooth, and if not treated, will result in an abscessed tooth causing pain and infection. Dr. Bailey and or Associates, will remove the decayed and weakened part of the tooth and replace it with tooth colored material to strengthen the tooth. A local anesthetic may be used that will "numb" the area being treated for one or two hours. By signing below it is understood that this office does NOT offer silver fillings, and if insurance is being billed, the patient may be responsible for any difference in the cost.

4. Stainless Steel Crowns. If a tooth is badly destroyed by decay, a filling will not stay in place. Therefore, a tooth is trimmed around the sides and a preformed crown or "cap" is placed over the tooth to protect it from breaking. Furthermore, anytime a Pulpotomy (see description below) is performed, a stainless steel crown will need to be placed. As with fillings, the area is usually treated with an anesthetic to help the child remain comfortable for one to two hours.

5. Caries susceptibility: Because of the thinness of the enamel on deciduous (baby) teeth, a tendency for children to consume excessive sweets, difficulty in brushing and flossing regularly, etc., there can often times occur large cavities very quickly in children's teeth. Special care must be taken to avoid these problems. Preventive measures would include fluoride treatments, placing sealants, thorough brushing and flossing, control of diet, regular dental checkups

6. Fracture or breakage: Due to the fragility of deciduous teeth it is often times difficult to retain fillings, especially large fillings, in these teeth no matter how well the fillings have been placed. If the child has a difficult time retaining fillings or if the cavities are initially very large it may be advisable to place stainless steel crowns on the teeth in order to preserve them until they should be normally exfoliated.

7. Pulpotomy: Due to the thinness of the enamel, large pulp (nerve) chambers, and rapid spread of caries (decay) in deciduous teeth, the dentist may drill into the pulp chamber during decay removal. Upon such pulpal or nerve exposure, extraction may often be avoided by rendering a treatment in which the pulp tissue in the upper part of the tooth is removed and replaced with various filling materials and the tooth preserved to maintain space and chewing capability until the permanent tooth replaces the deciduous tooth. This procedure is called a pulpotomy. At times, no matter how well done, these teeth may become infected and require extraction.

8. Abscesses: Deciduous teeth are particularly susceptible to a condition known as abscessing. Abscesses can occur if there has been deep invasion of caries into the tooth causing pulp tissue to become infected. The tooth usually becomes very sore and/or painful and swelling appears in the tissues near the root of the tooth. Abscesses may also occur from a traumatic injury to the tooth. The office should be contacted at once if this occurs. Pulpotomy as described above is generally not performed on an abscessed tooth and other alternatives must be considered.

9. Extraction and space maintenance: At times it is impossible to save a tooth. In such cases, the only alternative is to resort to extraction. Depending upon the necessity to maintain space for the eruption of permanent teeth it may be necessary to insert appliances known as space maintainers. These space maintainers may be either fixed or removable.

10. Responsibility: I acknowledge that it is my responsibility to immediately contact this office should any of the aforementioned or other adverse results occur following treatment. It is also my responsibility to set and keep appointments and follow instructions as given in order that proper dental health may be maintained for my child.

Parent/Guardian Initials:_____Date:_____

WEST VALLEY PEDIATRIC DENTISTRY

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered.

DENTAL INSURANCE: It is your responsibility to know your Insurance coverage. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company. Insurance balances over 60 days will be collected directly from you, and reimbursement will need to be collected from your insurance by you.

CHARGES: **A fee of $50.00 will be charged for appointments changed or cancelled without a 48 hour notice. We reserve the right to excuse patients from the practice after (2) rescheduled or cancelled appointments.** A service charge of 5% per month on the unpaid balance will be assessed on all accounts exceeding thirty (30) days from the date of service. A $30.00 fee will be charged on all returned checks or debits.

COLLECTION: In consideration for the professional services rendered to be rendered to me, or at my request, to my minor child by the dentist, I agree to pay the fees charged for the dental services provided to the dentist or his/her assignee at the time the services are rendered. I further agree to pay the remaining balance plus reasonable attorney fees, court costs and a collection agency commission of 40% of the delinquent balance if the account is assigned to a collection agency or attorney. I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, etc. to the dentist's collection agency or collection attorney should collection procedures as described become necessary.

I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care. I hereby agree to abide by the conditions outlined herein.

X _____ _____

Signature of, Parent or Guardian Date

Patient Name:_____

BEHAVIOR MANAGMENT TECHNIQUES

I authorize Dr. Samuel Bailey and/or Associate to use his judgment to decide when particular behavior management techniques are necessary to obtain cooperation for my child. Cooperation is necessary when performing dental procedures to allow for the safest possible treatment outcome. I give my written consent for the following procedures when necessary.

Tell-Show-Do

This technique is used to explain what is expected each visit. We tell them what will be done, show them how and then do what we have explained. Praise is used to reinforce cooperative behavior.

Voice Control

The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist voice without getting angry.

Restraint

Active: restraint by a dental personnel protects the child form injury during a dental procedure. The dentist or staff restrains the child by holding his/her head, arms or legs to prevent harmful movements.

Passive: restraint with a Pedi-wrap is used to prevent injury to an uncooperative child to enable the child to receive necessary treatment.

Nitrous Oxide

Nitrous Oxide or (laughing gas) is a routinely administered to anxious child through a small breathing mask, which is placed over the child's nose. This allows your child to relax but does not put them to sleep. The affects of this treatment will wear off after the mask is removed in approximately 5 minutes.

Sedation/Operating Room

If we are unable to gain your child's cooperation with the above procedures Dr. Bailey and or associates may recommend treatment under sedatives or general anesthesia. This is a separate appointment and will be discussed in further detail if recommended.

INFORMED CONSENT: I have been given the opportunity to ask any questions concerning the dental treatment of my child and have received answers to my satisfaction. I do voluntarily assume any and all possible risks, including but not limited to those addressed above, including the risk of substantial harm, if any, which may be associated with any phase of this treatment in hopes of obtaining the desired potential results, which may or may not be achieved. No promises or guarantees have been made concerning the results. The fee(s) for this service have been explained to me and are satisfactory. By signing this document, **I hereby state I have read and understand all the above information and give my written and implied consent to be treated by West Valley Pediatric Dentistry office of Dr. Samuel B. Bailey and/or Associate.**

Consent of Use and Disclosure of Health Information-HIPPAA Privacy

I have had full opportunity to read and consider the contents of this consent and the office's Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to this office's use and disclosure of my protected health information to carry out treatment, payment activities, and health care options.

_____ _____

Parent/Legal Guardian Signature Date