



## Pediatric Dentistry Health History

Child's Full Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Sex: M F

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN # \_\_\_\_\_ Best Phone # (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Grade: \_\_\_\_\_ School: \_\_\_\_\_

Name(s) and ages of other children in family: \_\_\_\_\_

Name(s) of your other children seen in this office: \_\_\_\_\_

Please list the child's hobbies/ interests: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Who is accompanying the child today? \_\_\_\_\_ Relation: \_\_\_\_\_

Who has legal custody of this child? \_\_\_\_\_

Insurance Company: \_\_\_\_\_ I.D. \_\_\_\_\_

### Parent/Legal Guardian Information

Parent's Marital Status:  Married  Divorced  Separated  Widowed  Single

**Mother**

**Step Mother**

**Guardian**

Name: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ State \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN # \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Home/Cell Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Email: \_\_\_\_\_

Employer: \_\_\_\_\_

Dental Insurance: Yes \_\_\_ No \_\_\_ Company \_\_\_\_\_

**Father**

**Step Father**

**Guardian**

Name: \_\_\_\_\_ Driver's License #: \_\_\_\_\_ State \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN # \_\_\_\_\_

Address: \_\_\_\_\_

Street City State Zip

Home/Cell Phone #: (\_\_\_\_) \_\_\_\_\_ Work Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_

Dental Insurance: Yes \_\_\_ No \_\_\_ Company \_\_\_\_\_

## Emergency Contact

His/Her Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Work Phone #: (\_\_\_\_) \_\_\_\_\_ Home Phone #: (\_\_\_\_) \_\_\_\_\_  
Cell/Mobil/Pager/Other Phone # (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

## Medical History

Child's Physician: \_\_\_\_\_

Phone #: (\_\_\_\_) \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Address: \_\_\_\_\_

Street

City

State

Zip

Is the child currently under the care of a physician?  Yes  No

If yes, please explain : \_\_\_\_\_

Please describe the child's current physical health:  Good  Fair  Poor

Are immunizations current?  Yes  No

Please list all medications that the child is currently taking: \_\_\_\_\_

Please list all medications/foods/other that cause the child allergic reactions: \_\_\_\_\_

### Has the child been diagnosed with or treated for any of the following:

<b>Y N</b> Abnormal Bleeding	<b>Y N</b> Cleft Palate/ Lip	<b>Y N</b> Hepatitis Type ____
<b>Y N</b> AIDS/HIV+	<b>Y N</b> Diabetes	<b>Y N</b> High/Low Blood Pressure
<b>Y N</b> Anemia	<b>Y N</b> Epilepsy/Seizures	<b>Y N</b> Hives
<b>Y N</b> Hospital Stays/Surgery	<b>Y N</b> Handicaps/Disabilities	<b>Y N</b> Kidney Problems
<b>Y N</b> Asthma	<b>Y N</b> Hearing/ Speech	<b>Y N</b> Liver Problems
<b>Y N</b> Blood Transfusion	<b>Y N</b> Heart Disease	<b>Y N</b> Rheumatic Fever
<b>Y N</b> Cancer	<b>Y N</b> Heart Murmur	<b>Y N</b> Sickle Cell Anemia
<b>Y N</b> Cerebral Palsy	<b>Y N</b> Hemophilia Type ____	<b>Y N</b> Tuberculosis (TB)

Please describe the above and any other medical problems the child has/had: \_\_\_\_\_

Does anyone in the family have a history of Malignant Hypothermia?  Yes  No

When was the child's last E.R. visit and why? \_\_\_\_\_

## Dental History

What is the Primary reason for today's visit? \_\_\_\_\_

### Is your child currently having problems with any of the following?

- Cavities                       Toothache                       Sensitive Teeth                       Trauma
- Gum Infection                       Color of Teeth                       Tooth Alignment                       Other \_\_\_\_\_

Has the child experienced problems with previous dental work?     Yes  No    Explain: \_\_\_\_\_

Is the child's home water supply fluoridated?                       Yes  No

Does the child brush his/her teeth daily with fluoride toothpaste?     Yes  No

Do you give the child any other form of fluoride?                       Yes  No

Does the child floss his/her teeth daily?                       Yes  No

Does your child suck a finger/thumb/pacifier/ or exhibit any other habits? \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Date of last visit? \_\_\_\_\_

Why did you leave your last dentist? \_\_\_\_\_

What did you like most about any dentist you have seen? \_\_\_\_\_

Least? \_\_\_\_\_

### Kids First Sedation and General Anesthesia Policy

All forms of sedation, nitrous, and general anesthesia are typically not covered by insurance. Payment for these procedures will be expected before booking. We will be glad to bill any insurance for all needed sedation options on your behalf, and will reimburse you if any payment is received.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to child \_\_\_\_\_



## Authorizations and Consent

**APPOINTMENTS** – In order to provide each child with the individual care and attention that they deserve, we ask that you arrive on time for scheduled appointments. We work very hard to see each patient at their scheduled appointment time. Due to the nature of our practice, however, when dealing with children, accidents and emergencies do happen. We ask for your patience if we are delayed in seeing your child due to treating another child on an emergency basis.

We require twenty four (24) hour notice if you must change a scheduled dental appointment. Less than 24 hour notice, or not showing for an appointment, is considered a missed appointment. Missing a scheduled appointment is counterproductive for both the patient and our office.

**CONTACT-** I agree to receiving text, emails, phone calls, mail and other forms of correspondence in regards to appointments, treatment and any other reasons by our office.

**PAYMENT** – Payment can be made by cash, check, and credit card. If paying by cash, please bring small bills. We usually do not have change for large bills. Fees for any treatment diagnosed will be discussed with you at your initial appointment. Payment arrangements/finance options are available through our office.

**INSURANCE** – Please provide the front office staff with your insurance card so that we can contact your insurance company regarding your benefits. We will file your insurance claims and work with your insurance company concerning their portion of treatment fees on your behalf. Remember, even if you have insurance coverage, you are responsible for payment of your account. Your insurance coverage is a relationship between you, the insured patient, and your insurance company. We have no influence over your coverage.

**PHOTO RELEASE** – I, the undersigned, do hereby relinquish any and all rights to photographs, portraits, transparencies, negatives, prints, Polaroid or other photographic reproductions captured with still, motion picture, video, digital or other cameras for use by this office.

**CONSENT FOR DENTAL TREATMENT** – I request and authorize Dr. Grewal and his staff to examine, clean, and provide dental treatment on my child’s teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Grewal to diagnose and/or treat my child’s dental problem. I will allow photographs to be taken of my child or my child’s teeth for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Grewal and his staff will provide an environment designed to help children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments, and using variable voice tone.

I have reviewed the information on the Health History Form and it is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child’s medical status. I agree to inform the office of any changes in address, phone, employment, etc... that occur during the course of treatment for my child. If the patient is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I understand that I will be responsible for any charges incurred for dental treatment.

Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Legal Guardian (if different): \_\_\_\_\_

# Kids First Pediatric Dentistry

## **Cancellation and Broken Appointment Policy**

We understand that illness, emergencies, auto issues, and bad weather do occur. We ask our patients to give us 24 hours' notice whenever possible if they cannot keep an appointment. This allows us to offer appointments to patients that are in pain or on a wait list.

### **Policy:**

#### **What is a Broken Appointment?**

Cancellation or rescheduling of an appointment with less than a 24 hour's notice will be considered a broken appointment and chargeable.

If you do not show up for an appointment, this is a chargeable broken appointment.

If you have 3 or more NO SHOW, NO CALL appointments, you will be scheduled to speak with our management team so we can work together to ensure you are able to make all future scheduled appointments.

### **Fees:**

Broken appointment with the Hygienist – \$25.00 per every half hour scheduled

Broken Appointment with the Dentist -\$50.00 per every half hour scheduled

Our number one concern is our patient's dental health. Providing services in a timely manner is critical in accomplishing that goal. Another goal is to keep the cost of dental treatment as economical as possible. The appointment you schedule for treatment is reserved for YOU! When you fail your appointment without providing us with adequate notice, this adds to the overall cost of care.

If we are unable to reach you to verbally confirm your appointment by noon the day before you are scheduled, we will have to assume that you will not be able to make it and your appointment will be taken out of our schedule.

We understand emergencies come up and therefore charges for broken appointments will be at the discretion of the Management Team. We appreciate your understanding and consideration regarding our Broken Appointment Policy. If you have any questions or concerns do not hesitate to contact us at 313-386-0570.

I have read, understand and agree to the above policy.

\_\_\_\_\_

Patient Signature

Date

# **KIDS FIRST GUIDE TO BEHAVIOR MANAGEMENT TECHNIQUES**

## **TELL-SHOW-DO**

The technique involves verbal explanations of procedures at age-appropriate levels (Tell); demonstrations for the patient of the aspects of procedures (Show); and then, without deviating from explanation and demonstration, completion of the procedure (Do).

### **OBJECTIVES:**

- Teach the patient important aspects of the visit and familiarize the patient with the dental setting.
- Shape the patient's response to procedures through desensitization and well-described expectations.

## **VOICE CONTROL**

Voice control is a deliberate alteration of voice volume, tone, or pace to influence and direct the patient's behavior. While change in tone may be readily accepted, use of an assertive voice may be considered harsh to some parents unfamiliar with this technique.

### **OBJECTIVES:**

- Gain the patient's attention and compliance
- Avert negative or avoidance behavior
- Establish appropriate adult-child roles

## **POSITIVE REINFORCEMENT**

In the process of establishing desirable patient behavior, it is essential to give appropriate feedback. Positive reinforcement rewards desired behavior thereby strengthening the likelihood of recurrence of those behaviors. Positive reinforcers include voice modulation, facial expression, verbal praise, appropriate physical demonstrations, tokens, and toys.

### **OBJECTIVES:**

- Reinforce desired patient behavior

## **DISTRACTION**

Distraction is the technique of diverting the patient's attention from what may be perceived as an unpleasant procedure. Playing music, singing, TV shows/movies, giving the patient a short break during stressful procedures, can be effective distractions.

### **OBJECTIVES:**

- Decrease the perception of unpleasantness
- Avert negative or avoidance behavior

## **MEMORY RECONSTRUCTING**

A behavioral approach in which memories associated with a negative or difficult event (e.g. first dental visit, local anesthesia, restorative procedure, extraction) are restructured into positive memories using information suggested after the event has taken place. Restructuring involves four components: (1) visual reminders; (2) positive reinforcement; (3) concrete examples to encode sensory details; and (4) sense of accomplishment.

### **OBJECTIVES:**

- Restructure difficult or negative past dental experiences
- Improve patient behaviors at subsequent dental visits

### **ASK-TELL-ASK**

This technique involves inquiring about the patient's visit and feelings toward or about any planned procedures (ask); explaining the procedures through demonstrations and age-appropriate language (tell); and again inquiring if the patient understands and how they feel about the impending treatment (ask).

#### **OBJECTIVES:**

- Assess anxiety that may lead to noncompliant behavior during treatment
- Teach the patient about the procedures and how they are going to be accomplished
- Confirm the patient is comfortable with the treatment before proceeding

### **NONVERBAL COMMUNICATION**

The reinforcement and guidance of behavior through appropriate contact, posture, facial expression, and body language.

#### **OBJECTIVES:**

- Enhance the effectiveness of nonverbal communicative management techniques
- Gain and maintain the patient's attention and compliance

**I have read and understand that many types of behavioral management techniques may be used to ensure the best experience for my child.**

**This is a billable service to your insurance carrier per the American Dental Association, additional fees may apply.**

**We do our best to create a comfortable, safe, and happy environment for your child. This helps to ensure the success of their oral health and instill good habits for years to come.**

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**Parent/Guardian Signature**

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**Date**