

Lago Vista Family Dentistry

www.LagoVistaFamilyDentistry.com

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New Patient Information

Please let us know about your child's medical and dental history so we may serve you more effectively and in a manner that helps with the overall health and well-being of your child.

We realize that not all questions will pertain to your child. If you have questions, please ask and we will help to better explain the question.

Chart#: _____

FOR OFFICE USE ONLY

Patient Name: _____

Last

First

MI

Preferred Name

Title: _____

Gender: Male Female

Family Status: Married Single Child Other

Mr/Ms/Mrs/etc

Birth Date: _____

Prev. Visit: _____

Email Address: _____

Phone: _____ Best time to call: _____

Home

Mobile

Work

Ext

Address: _____

Address 1

Address 2

City

State

Zip Code

Who does the child live with?

Mother Father Guardian Grandparents

Siblings who are or who have been a patient in our office:

Is there anything that you would like to discuss with the Dentist in private, alone, or away from your child? Yes No

What is the reason for seeing the dentist today?

First Visit Check-up Pain Other

Whom may we thank for referring you to our practice? Please mark the correct box and name them below.

Another Dental Office Phonebook Friend Driving by Internet School
 Work Other (name below): _____

Guardian Information

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First MI Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____

SS#: _____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

Employer

Dental Benefits Plan

Primary
Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Plan phone number _____

Secondary
Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Plan phone number _____

Child's Medical & Dental History

Within the past year have there been any changes in your child's general health? Yes No

What is the approximate date of your child's last medical exam? _____

Your child's pediatrician name and phone number: and list all medications currently taking.

Please indicate if your child has experienced any of the following.

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> *Pre-Med - Amox | <input type="checkbox"/> *Pre-Med - Clind | <input type="checkbox"/> *Pre-Med - Other | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Allergy - Aspirin | <input type="checkbox"/> Allergy - Codeine | <input type="checkbox"/> Allergy - Erythro | <input type="checkbox"/> Allergy - Hay Fever |
| <input type="checkbox"/> Allergy - Latex | <input type="checkbox"/> Allergy - Other | <input type="checkbox"/> Allergy - Penicillin | <input type="checkbox"/> Allergy - Sulfa |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Fainting | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Other |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Venereal Disease | | | |

- *
- | | |
|---|---|
| <input type="checkbox"/> Had complications with or after dental treatment. | <input type="checkbox"/> Currently under the care of a physician due to a specific condition. |
| <input type="checkbox"/> Has been seen by a cardiologist. | <input type="checkbox"/> Been admitted to a hospital in the last 5 years due to a surgery or illness. |
| <input type="checkbox"/> Taking any prescription or non-prescription medications. | <input type="checkbox"/> Tobacco use (chewing or smoking.) |
| <input type="checkbox"/> Any other conditions, diseases, etc. not listed above. | <input type="checkbox"/> Does your child currently use fluoride supplement. |

If any of the previous questions are marked, please explain:

When was your child's last dental appointment? What was done at that last dental visit?

How frequently does your child brush their teeth?

- 3+ a day Twice a day Once a day Weekly Seldom By parent By child Both

How often does your child floss?

- Once daily Occasionally Never By parent By child

Does your child do any of the following?

- Lip sucking/biting Pacifier Nail biting Finger/thumb sucking Nursing/bottle Grinds his teeth
- Sores

Consent for Services

*To the best of my knowledge, all of the preceding information is true and correct. If there is any change in my child's health I will inform the office at my child's next dental appointment.

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnoses and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice, to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependents.

* I have read the above conditions of treatment and payment and agree to their content.

PEDIATRIC DENTISTRY CONSENT FOR ANXIETY REDUCING TECHNIQUES

Please read this form carefully and ask questions about anything you do not understand. Please check each box to identify that you understand this technique.

All effort will be made to obtain the cooperation of child dental patients by the use of Tell - Show - Do with friendliness, persuasion, humor, charm, gentleness, kindness and understanding. In some cases, further techniques are needed when providing operative care such as fillings, etc. In order to gain cooperation, eliminate disruptive behavior or prevent a patient causing injury to themselves, it may be necessary to use other anxiety reducing techniques.

Tell-Show-Do: The dentist or dental team explains to the child what is to be done using simple, kid-friendly terminology and repetition, then shows the child what is to be done by demonstrating with instruments on a model or the child's or the dentist's finger. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive reinforcement: This technique rewards the child who displays behavior which is desirable with compliments, praise, pat on the back, or a prize.

Mouth Props/Rubber Dams: A mouth prop, or tooth pillow as we call it, is used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc). This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a raincoat placed on the area to be worked on to isolate the teeth, and to prevent any debris from being swallowed or from going to the back of the throat.

Immobilization by the dentist: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the dentist gently holds the child's hands or upper body, stabilizing the child's head between the dentist's arm and body.

Immobilization by the assistant: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the assistant gently holds the child's hands and stabilizes the child's head and/or legs.

Relaxation Gas: Nitrous Oxide (laughing gas) and oxygen may be recommended to relax the child. This allows the child to sit in the chair longer, increases their attention span and allows the treatment to be completed in a comfortable manner for the child.

Voice Alteration: A controlled alteration (increase or decrease) of voice, tone, or pace to influence and direct the patient's behavior.

Relationship to patient

Mother Father Guardian Other

By checking this box, I acknowledge that I have read this statement and agree to the contents.

Signature _____ Date _____

Response Date: _____