

***WELCOME TO OUR OFFICE!***

**PLEASE TELL US MORE ABOUT YOUR CHILD.**

**YOUR CHILD**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: M F Age: \_\_\_\_\_\_

Home Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birthdate:** \_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_ HomePhone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Grade:\_\_\_\_\_\_

**Referred by:\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARENT OR GUARDIAN INFORMATION (MOTHER OR GUARDIAN)**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_

Address: (if different than child’s)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip:\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PARENT OR GUARDIAN INFORMATION** (FATHER OR GUARDIAN)

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_Zip:\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Insured’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_

Social Security # \_\_\_\_\_\_\_-\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Birth date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Insurance Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group#\_\_\_\_\_\_\_\_\_\_\_\_\_ID#\_\_\_\_\_\_\_\_\_\_\_\_

Ins. Co. Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_Zip:\_\_\_\_\_

**FINANCIAL ARRANGEMENTS**

For your convenience we offer the following methods of payment. Please check the option you prefer. Payment in full is due at each appointment**. \_\_\_\_Cash \_\_\_\_\_\_Personal** **Check \_\_\_\_\_Visa \_\_\_MasterCard**

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent’s behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

**Signature of Parent or Guardian**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH HISTORY**

Child’s Full Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your child most interested in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Siblings, names and ages?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who lives with the child\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Child’s pediatrician or physician\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL** Has your child had any of the following medical problems? *Circle Yes (Y) or No (N).*

Allergies to drugs or foods Y N:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reaction:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
  
Heart murmur Y N Hemophilia or abnormal bleeding Y N Allergies to Latex Y N Hepatitis Y N Cancer Y N High fevers Y N Convulsions or epilepsy Y N Hospital stays operations Y N Developmental delay Y N HIV+ /AIDS Y N Diabetes Y N Learning disabilities Y N Ear infections Y N Rheumatic fever Y N Handicaps or disabilities Y N Trauma to mouth or face Y N Heart defect (congenital) Y N Tuberculosis (TB) Y N Asthma or lung problems Y N Cerebral Palsy Y N Blood transfusion Y N Attention Deficit Disorder Y N   
Autism Y N

Other medical problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? Y N

Is your child currently taking any medications? Y N What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child taking any supplemental fluoride? Y N If yes, how? Tablets, drops, water, vitamins (please circle)

Does your child have any breathing problems? Y N Breathes primarily through nose or mouth? (please circle)

**HABITS**

*Please circle if your child has any of the following habits:* Thumb or finger sucking Pacifier use Nail biting Snore Lip sucking or biting Biting hard objects Tooth grinding

Does your child currently use a bottle? Y N If yes, how often during the day? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the bottle used at night? Y N What do you put in the bottle? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child currently nurse? Y N

**FAMILY DENTAL HISTORY** *(Circle appropriate parent, if yes)*

Has Mother or Father had a lot of decay?\_\_\_\_ Has Mother or Father had orthodontic care?\_\_\_

Does Mother or Father have periodontal disease?\_\_\_ Does Mother or Father have TMJ problems?\_\_\_  
**CHILD’S DENTAL HISTORY**Has your child seen a pediatric dentist before? Yes NoIf yes, the approximate month and year of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Has your child had any unfavorable experiences in a dental or medical office? Yes NoDoes your child have any dental problems presently? Yes No if yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_How often does your child brush/floss his/her teeth per day? \_\_\_\_\_\_ Do you help? Yes NoHow do you think your child will act toward the dentist?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Purpose of today’s dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Guardian’s Initials\_\_\_\_\_\_\_\_\_\_\_\_**

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**Request and Consent for Dental Treatment**

Please read this form *carefully*. If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it.

1. I request and authorize the dental treatment by Dr. Jorge Landa and staff.

Patient Name:

1. I am the legal guardian of the child named above. (**Initials**)
2. I further request and authorize the taking of dental x-rays, necessary dental cleanings, application of fluoride gel, and the use of such anesthetics as may be considered necessary to treat my child’s dental need(s).
3. I have had explained to me by Dr. Landa and staff, and have had sufficient opportunity to discuss the patient’s dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.
4. It is unusual for any of the following risks or complications to occur. These risks or complications include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.
5. **I understand** that during the course of the patient’s dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient’s treatment plan and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the, practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.
6. **I understand** it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion, humor, charm, gentleness and kindness and understanding. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.
7. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and or doctor to hold the patient’s hands, stabilize the head and/or control leg movements for their safety. I also understand the routine use of “tooth pillows” (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their mouth that could harm them. I also understand that mouth props are sometimes necessary if a child refuses to open their mouth.

1. **I understand** that it is not an uncommon response for children to cry before or during dental treatment or directly afterward when they see their parent. **I understand** the only way I can guarantee my child will not cry or be unhappy during dental treatment is if I elect to have their treatment completed in the operating room under general anesthesia. I also know conscious or IV sedation is an option for some children.
2. **I further understand** that should the patient become uncooperative during emergency dental or sedation procedures with excessive body movements, the patient may need to be wrapped in a “hug blanket” called a pediwrap to prevent injury and enable Dr. Landa to safely provide the necessary treatment. *I will be consulted prior to the use of the pediwrap.*
3. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.
4. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.
5. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.
6. **I confirm** that I am a legal guardian to the child referenced on the opposite page. **I also confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

**X**

Signature of Person Consenting to Treatment Date

Signature of Doctor Date



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of this office's Notice of Privacy Practices. (Parent’s/ Guardian name)

{Signature}\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

{Date} \_\_\_\_\_\_\_\_\_\_\_ [Email}\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 refuse to sign;

 Communications barriers prohibited obtaining acknowledgement;

 An Emergency situation prevented us from obtaining acknowledgement;

 Other (Please Specify)



**Missed Appointment Policy**

It is our wish that each and every one of our patients receive the very best care and service possible. Appointments are opportunities to render care to all of our patients. Your treatment plan consists of a specific series of appointments given over a pre-planned time frame. It is important that you follow this plan for optimal health and desired results.

If we did not insist that you meet all your appointments, we would be doing you a disservice. Therefore we have a few simple guidelines in canceling an appointment:

1. Keep all your scheduled appointments. Arrange activities so this can occur.

2. If you are unable to make an appointment due to an emergency, please call us and let us know so we can reschedule you appointment.

3. With the exceptions of unexpected emergencies we require that you notify us **at least 24 hours** in advance as to any appointment changes. Missed appointments may be subject to a $25 missed appointment fee.

4. All cancelled or missed appointments must be rescheduled. Presenting more than 10 minutes late for a confirmed appointment = a missed appointment. No walk-ins allowed.

**5. Failure to give 24-hour notice of a missed appointment on two occasions will result in inactivation from our patient roster without the right of future appointments.**

**ANY APPOINTMENT THAT IS NOT CONFIRMED VIA PHONE CALL OR EMAIL 24 HOURS PRIOR, IS SUBJECT TO CANCELLATION BY PDK. PLEASE CONFIRM YOUR APPOINTMENT 24 HOURS PRIOR.**

Thank you! *I have read and understand the above mentioned policy.*

Patient name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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