ISLAND
PEDIATRIC DENTISTRY
516.437.6000

ABOUT YOUR CHILD

Name _____

Nick Name _____

( ) Female ( ) Male

Birthdate _____

School _____

Home Address

_____

_____

DENTAL INSURANCE

Name _____

Employer Name _____

Policy Holder Name _____

Policy Holder Birthdate _____

Policy Number _____

Group Number _____

Social Security Number

_____

MOTHER'S INFORMATION

Name _____

Home Address ( ) same as child

_____

_____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

Family _____

Friend _____

Online _____

Other _____

FATHER'S INFORMATION

Name _____

Home Address ( ) same as child

_____

_____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

ANY PERTINENT INFORMATION YOU'D LIKE TO SHARE.

DENTAL HISTORY

Is this your child's first visit to the dentist? ( ) Yes ( ) No
If not, when was the last visit?

_____

Previous dentist's name

_____

In the past, has there been any injuries to the teeth, mouth or face? _____

_____

_____

Why did you bring your child to the dentist today?

_____

_____

_____

Has your child ever had problems associated with previous dental work?

_____

_____

The following answers will help us better serve our patients. Thank you.

Child brushes twice a day with fluoride toothpaste under supervision.	Yes	No
Child flosses daily under supervision.	Yes	No
Child drinks fluoridated water or/and takes fluoride supplements such as pills or rinse.	Yes	No
Child has regular dental care.	Yes	No
Child experienced cavities before.	Yes	No
Child has more than 3 snacks a day.	Yes	No
Child goes to bed with a bottle containing other than water.	Yes	No
Child has special healthcare needs.	Yes	No
Parents/caregiver have active cavities.	Yes	No

MEDICAL HISTORY

Has your child ever had any of the following condition?

Immunization up to date	Yes	No
Allergies to drugs	Yes	No
Allergies to food	Yes	No
Hospitalization	Yes	No
Surgeries/Operations	Yes	No
Cancer	Yes	No
Asthma	Yes	No
Congenital birth defects	Yes	No
Epilepsy/Conversions	Yes	No
Tuberculosis	Yes	No
Pregnancy	Yes	No
ADD/ADHD	Yes	No
Autism spectrum disorder	Yes	No
Emotional conditions	Yes	No
Special needs	Yes	No
Hearing impairment	Yes	No
Heart disease/Murmur	Yes	No
Hemophilia/Blood disorder	Yes	No
Hepatitis	Yes	No
HIV+/AIDS	Yes	No
Kidney condition	Yes	No
Liver condition	Yes	No
Rheumatic/Scarlet fever	Yes	No
Diabetes	Yes	No
Antibiotics prior to dental procedure needed	Yes	No
Syndromes	Yes	No

Please list any other medical conditions your child may have. ( ) None

_____

_____

Please list all drugs your child is taking. ( ) None _____

_____

Child's physician _____

Physician number _____

Please describe your child's current health.

( ) Good ( ) Fair ( ) Poor

I certify that the information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes. I authorize the dental staff to perform necessary dental services my child may need.

Parent/guardian Signature Date Relationship to patient

Insurance & Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we work hard to provide you with payment information in advance to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

Your Dental Insurance:
Your dental insurance benefits are based upon a contract made between your employer and the insurance company. Dental plans rarely pay 100% of dental care. It is only to assist you partially. If you have any questions regarding the terms of your benefit, please contact your HR department or the insurance company directly.

We accept many insurance plans. This means we literally work with thousands of different insurance plans. Although we maintain computerized histories of payment by a given company, they do change over time; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we recommend filing a "pre-treatment authorization" prior to treatment. Keep in mind this is not a guarantee of coverage. This does delay treatment but will give you the exact out of pocket expense.

Your deductible and co-payment are expected to be paid in full (cash or credit card) at the time of service. We do not bill patients after treatment is completed to avoid confusion and delinquency.

Non-insurance Payments:
We offer a 30% accounting paperwork courtesy for all treatment that is paid in full (cash or credit card) at the time of service.

Broken appointments:
A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, please inform us at least 24 hours in advance.

I have received, read and agree to the above financial policy.

Patient Name

Parent/Guardian Name Parent/Guardian Signature Date

BEHAVIOR MANAGEMENT TECHNIQUES INFORMATION

It is our intent that all professional care delivered in our dental office shall be of the best possible quality we can provide for each child. Our mission is to deliver care in a manner, which leaves your child with good positive feelings about going to the dentist. The entire focus is on your child, relating to them, fostering good dental health habits and instilling a healthy, positive attitude toward dentistry for life.

All efforts will be made to obtain the cooperation of child patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding. In some cases, further behavior management techniques are needed. 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. These techniques are not a form of punishment and are in no way used as a form of punishment. These techniques are simply used only when and, if necessary, to complete a dental procedure in the safest manner possible.

Please read this form carefully & ask about anything you do not understand. Please initial to identify you understand the techniques we use.

The following are everyday-use-techniques that work well with children who are willing to listen and follow directions.

1. Tell-show-do: The doctor 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. Negative reinforcement: Similar to positive reinforcement in many ways but the child will lose privileges if uncooperative. He/she is then promised to re-gain the lost privilege back upon improving his/her behavior.
4. Voice control: Is a controlled alteration of voice volume, tone, or pace to influence and direct the patient's behavior.
5. Mouth prop/rubber dam/Isolite: A mouth prop is used to help support your child in keeping his/her mouth open during an operative procedure. This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam or Isolite is an "umbrella protection" placed on the area of work to be worked on to isolate the teeth and prevents any debris from being swallowed or going to the back of the throat.
6. Movement elimination by the doctor: The doctor controls the child from movement by gently holding down the child's hands or upper body, stabilizing the child's head between the dentist's arm and body.
7. Movement elimination by the assistant: The assistant controls the child from movement by gently holding the child's hands, stabilizing the head, and/or controlling leg movements.
8. Laughing gas: Nitrous oxide and oxygen may be administered to relax the child and to raise his/her pain threshold. This allows the child to sit in chair longer and increases their attention span and allows for more work to be done without the child labeling something as painful. Nitrous oxide and oxygen is not general anesthesia. The child is not "put to sleep" and does not become unconscious, only relaxed.

The following techniques are available for children who cannot/won't listen and follow directions voluntarily. **These techniques will be utilized ONLY after obtaining the PARENT'S CONSENT.**

1. Immobilization by papoose wrap: A passive restraint device, designed specifically for pediatric dental procedures, is used when complete immobilization is needed for the safety of the patient and the dental team. It is used during urgent or emergency procedures.
2. Deep sedation or general anesthesia: Is recommended for apprehensive, very young children, and medically compromised patients. The majority of children respond very well for dental treatment. For various reasons, some children may be apprehensive about dental treatment and may require some form of sedation/general anesthesia to allow treatments.

BEHAVIOR MANAGEMENT TECHNIQUES

ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

1. I hereby acknowledge that I have read and understand this consent.
2. I was given a chance to ask any questions or express any concerns I have.
3. I am clear and understand that none of the above techniques are used in any way as punishment. These procedures are standard of care in the pediatric dental community and used to provide the best dental care.
4. I acknowledge that I have not been coerced/ forced to sign this consent and that I have been given the alternative to withdraw from it.
5. I hereby authorize and direct Dr. Sara Seo assisted by other doctors and/or dental auxiliaries of her/his choice, to utilize, if required, the necessary patient management techniques to assist in the provision of the required dental treatment for my child.
6. I understand that this consent shall remain in effect until terminated by me.

_____	_____	_____	_____
Patient Name	Person Authorized to Consent	Relationship To Patient	Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Patient Name | Date

Parent/Guardian Name | Signature

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 refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

APPOINTMENT POLICY

Promises are important to keep. We teach our children to honor their promises. When we make appointments, we are making promises to be available for each other at a given date and time. Appointments are the very basics of running our office efficiently and they are important to us. When you do not show up for your scheduled appointment or cancel last minute, not only does it cost the doctor's time but it also costs other patient's time as well. That wasted appointment time could have been given to someone else who really needed it.

We pride ourselves in being able to take our appointment patients immediately back to see the dentist. Our wait time in the waiting room is no more than 30 minutes. We work extremely hard to be efficient so that we do not waste your time. We will send you multiple reminders at no cost via email or text.

We try our best to accommodate all appointment requests but we need your help in doing that. PLEASE CALL US WITHIN 24 HOURS OF YOUR APPOINTMENT TIME IF YOU CANNOT KEEP YOUR APPOINTMENT. Nobody enjoys being stood up without a notice. Habitual appointment breakers will be double-booked in the future; this means they will have to wait longer in the waiting room. Thank you for your cooperation.

I was informed of the appointment policy and I understand it.

Patient Name Guardian Name Signature Date