Patient Information

Patient's Name _____ Nickname/Name Preferred _____ ❑ Female ❑ Male

DOB _____ Age _____ School _____ Grade _____

Address _____ City _____ State _____ Zip Code _____

Cell # for Scheduling _____ Email _____ Hobbies/Interests _____

Has siblings already in our practice? Yes No Whom may we thank for referring you to us? _____

Who brought the child in today? _____ Relationship to child _____ Interpreter needed? Yes No

Legal Guardian: Yes No If "No", who has legal custody? Name _____ Phone _____

Whom may we contact (outside household) in case of an emergency? Name of contact _____ Phone _____

Dental History

Purpose of today's visit: _____

Yes No Is this your child's first visit? If No, when was their last visit? _____ Previous Dentist _____

Yes No Has your child ever had an unfavorable dental/medical experience? Explain _____

Yes No History of injury to teeth or face? Explain: _____

Yes No Does/did your child suck their thumb, fingers or pacifier? If yes, what age did they stop? _____

Yes No After age 1, does your child currently drink from a bottle, sippy-cup (or nurse on demand) while sleeping at night?

Yes No Regularly drinks sweet tea, soda/diet soda, sports drinks, juice, or flavored milk? How many glasses per day? _____

Yes No Child snacks regularly on candy, or carbohydrate type snacks? (Examples: fruit snacks, granola bars, chips/crackers, etc…)

Yes No Brushes teeth with fluoride toothpaste

Yes No Child brushes teeth without adult assistance

Yes No Flosses regularly (# of times per week _____)

Yes No Other than water - eats/drinks after evening tooth brushing

Yes No Clenches/grinds teeth or chews fingernails

Yes No Tongue tied or tongue thrust habit

Yes No Child spits toothpaste out well

Yes No Takes fluoride supplements

Yes No Water is fluoridated

Yes No Interested in orthodontics or athletic mouth guard

Yes No TMJ pain, popping, or clicking. Explain _____

Yes No Mouth breather, snoring or apnea. Explain _____

Medical History

Yes No Child receives regular medical exams? Physician's Name _____ Phone _____

Yes No Taking Rx medications, OTC medications, or herbal supplements? If yes, please list name of all drugs and reason for taking. _____

Yes No Has allergies/adverse reactions to medications such as lidocaine, amoxicillin, etc. Or materials such as latex, nickel/metals, plastics. Please list all allergies:

Yes No Immunizations up to date?

Yes No *Heart condition* Explain _____

Yes No Hospitalizations/Surgeries? Explain _____

Yes No Choose not to immunize

Yes No Requires antibiotics prior to dental treatment?

Yes No General Anesthesia complications for child or family

Has the child ever experienced, diagnosed or been treated for any of the following?

Yes No ADD/ADHD
Yes No Artificial Bones/Joints/Valves
Yes No Blood Disorder for Child or Family
Yes No Cancer/Tumors - type: _____
Yes No Cognitive Mental Delays
Yes No Epilepsy or Seizures
Yes No Food Allergies - type: _____
Yes No Kidney Problem
Yes No Mental/Psychiatric Illness
Yes No Pregnant (or Possibly Pregnant)
Yes No Seasonal Allergies (Takes Shots)
Yes No Tuberculosis (or Exposure to TB)
Yes No Abnormal Bleeding/Bruising

Yes No AIDS/HIV+
Yes No Asthma or Lung Problem
Yes No Blood Pressure Problem
Yes No Cerebral Palsy
Yes No Diabetes - type: _____
Yes No GERD/Reflux
Yes No Hearing Impairment
Yes No Liver Problem or Hepatitis
Yes No MRSA or Staph Infections
Yes No Premature Birth (<36weeks)
Yes No Speech Delay
Yes No Visual Impairment
Yes No Other Conditions: _____

Yes No Anemia, Sickle Cell
Yes No Autism, Asperger's or PDD
Yes No Down Syndrome
Yes No Cleft Lip or Palate
Yes No Eating Disorder _____
Yes No GI Problem (Crohn's, Colitis…)
Yes No Heart Murmur (if still present)
Yes No Lupus or Immune Problem
Yes No Organ Transplant
Yes No Rheumatic Fever
Yes No Thyroid Disorder _____
Yes No Weight Related Concerns

* If your child has a history of heart murmur, heart surgery, heart defect, or a bleeding disorder it is usually necessary for us to review information with your child's physician prior to dental treatment. Please contact us to help initiate this process so we can best serve your child promptly. *

I, the responsible party or parent/legal guardian, acknowledge that information above is accurate and will update the doctors with any changes prior to future treatment.

Name _____ Signature _____ Date _____

Office Use Only

Doctor's Note:

Date _____

Signature _____

Yes No Medical Consult Required

Parent / Legal Guardian Information

Mother of Child _____
Address _____
City, State, Zip _____
Cell _____ Email _____
Work Phone _____ Occupation _____

Father of Child _____
Address _____
City, State, Zip _____
Cell _____ Email _____
Work Phone _____ Occupation _____

Dental Insurance Information

You do not need to fill out the dental insurance info below if a copy was made of your insurance card today.

Primary Insurance Co. Name _____
Policy Holder's Name _____ DOB _____
Insurance ID# _____ SS# _____
Group or Plan # _____ Employer _____
Insurance Co. Phone _____
Ins. Co. Address: _____

Secondary Insurance Co. Name _____
Policy Holder's Name _____ DOB _____
Insurance ID# _____ SS# _____
Group or Plan # _____ Employer _____
Insurance Co. Phone _____
Ins. Co. Address: _____

Child is enrolled in Medicaid (NC Tracks) Yes No If Yes, Child's Name _____ ID# _____

Consent for Dental Treatment when Accompanied by an Authorized Adult

I, the Parental/Guardian, give my consent for other adults (ages 18 +) to accompany my child to and from future dental appointments and to make treatment decisions concerning my child, and any of my other children who are patients of Children's Dentistry of Greensboro, on my behalf when I am not present. I also affirm that the responsible party listed below has a full understanding and updated knowledge of my child's health history for each visit to our office. *If an older responsible sibling of driving age under 18 brings the child in question for an exam (exams only please) I agree to call the office on the day of the appointment, before their appointment, to confirm the absence of any health changes of the child and to authorize proposed treatment. Your child may have their appointment cancelled, if they are brought in by someone under 18, or if the accompanying adult is not listed by you below and you can not be reached by phone.*

Name of Authorized Adult #1 _____ Relationship to Child _____
Name of Authorized Adult #2 _____ Relationship to Child _____

It is most helpful for your child, that the parent/guardian attends every new patient exam unless there are unusual circumstances.

Appointment Policy

We strive to see your family and all our patients on-time for every appointment, and yet we also give preferential scheduling for emergencies and dental trauman and ask you to remember that kids are sometimes unpredictable and this can affect our schedule as well. We will give every family at CDG the time their child deserves and requires. Please arrive at your appointment on time and arrive 15 minutes early if paperwork needs to be completed. At CDG we don't think you should wait in our lobby, because the family in front of yours was late for their appointment. Consequently, families that are late may have their appointment cancelled/rescheduled. We understand that cancellation of appointments is sometimes necessary, but whenever possible please contact our office 48 hours in advance, so that we may serve other children that need that appointment. Repeat "No-Show" appointments without calling in advance, or failure to comply with our scheduling policy and treatment recommendations can harm your child's dental health and lead to pain and or infection. Non-compliance with this policy, may also lead to dismissal from the practice for your child/family.

Responsible Party Policy

The parent/guardian who brings the child to our office and signs this paperwork will be responsible for all payments. All statements will be sent to this individual. We will not bill a third party other than an insurance company, although we will gladly print receipts for service and payments. If you have any questions regarding the procedures or the financial portion of any treatment plan, please discuss these issues with our treatment coordinator prior to starting treatment.

Consent for Payment

As parent/guardian of this child, I hereby grant authorization for Dr. Thane Hisaw to accomplish necessary dental treatment for my child. Furthermore I acknowledge that I will be responsible for any bill incurred by treatment on this child, regardless of what my insurance coverage approves, including reasonable attorneys fees and costs of collection in the event of default. In certain circumstances I authorize payment of insurance benefits to Dr. Hisaw that were initially sent to me by my insurance company. Our office will do our best to provide you with estimated portions of your bills prior to treatment, and will always be available for any questions, but I accept that my dental insurance carrier may pay less than the actual bill. I authorize this office to file claims on my behalf and give permission for benefits to be paid directly to Dr. Hisaw. I understand that any estimated costs not covered by my insurance are due at the time of service.

All of the information I have provide is truthful and my signature below confirms that I have read and agree to comply with the following office policies: Consent for Treatment when Accompanied by an Authorized Adult, Cancellation/Broken Appointment Policy, Responsible Party, and Consent for Payment.

Signed _____ Date _____
Responsible Party/Parent or Legal Guardian

Consent for Dental Procedures

Please read this form carefully and ask about anything that you do not understand. We will be pleased to help further your understanding.

I hereby authorize and direct the staff members of the office of Thane C. Hisaw, DMD, PA to perform upon my child the dental procedures for which they are qualified. This may include the use of any necessary or advisable local anesthesia, radiographs (x-ray pictures) or diagnostic aids. I understand that specific dental/surgical procedures for my child will be explained. In general terms, the procedures may include the following:

- Cleaning of teeth and the application of topical fluoride.
- Application of plastic BPA-free "sealants" to the grooves of teeth to protect against cavity formation.
- Treatment of diseased or injured teeth with tooth colored dental restorations/fillings (We don't use amalgam with mercury).
- Rarely a stainless steel crown (non-mercury safe to use metal cap) may be required to restore a severely damaged molar tooth in the back of the mouth. Please note that we always offer the most esthetic restorations and as the first and preferred treatment option.
- Replacement of missing teeth with appliances to hold space for permanent teeth.
- Treatment of the pulpal (nerve) conditions when indicated, often called a "pulpotomy or kiddie root-canal".
- Removal (extraction) of one or more teeth.
- Treatment of diseased or injured oral tissues.
- Replacement of missing teeth with dental prostheses (false teeth).
- Use of nitrous oxide and oxygen inhalation analgesia (laughing gas) to help reduce apprehension.
- Restraint, although rarely needed is used to provide safety for the patient and dental staff. Restraint in our office involves a parent or assistant gently and kindly holding the child's hand so that they don't injure themselves on any instruments during treatment.
- Use of behavior management techniques when necessary such as: Tell-Show-Do, Positive Reinforcement, "Mouth-Chair" type Prop (to aid in patient comfort and safety), Distraction Techniques, and rarely a mild change in tone of the doctor's voice to help the child cope and cooperate best.
- Additional consents are required for Hospital Dentistry under General Anesthesia, or Sedation Dentistry.
- Other: _____

This treatment has been explained to me. Alternate methods, if any, have also been explained to me as have the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated; therefore, there can be no guarantee, expressed or implied, as to the result of the treatment or cure. I further authorize the qualified staff members of the office of Thane C. Hisaw, DMD, PA to perform other dental services that are advisable for my child with the exception of the following treatments: _____.

Some inherent risks accompany the dental procedures noted above; however, these occurrences are infrequent.

- Local anesthetic (such as Lidocaine or Novocain) is used to make teeth numb so that dental treatment will not hurt. When it is used, the child may chew the cheek, lip, or tongue while they are numb. Soreness of the mouth, gums, and/or jaws may occur after dental treatment. Permanent numbness, although it is rare, can occur.
- Bleeding, pain, or swelling, or may occur following removal of a tooth. Temporary or permanent numbness of the tongue or lip (paresthesia) may also occur. Additional complications although also very rare, may include but are not limited to injuries to the face, jaw, teeth and/or other oral structures. In specific circumstances, small pieces of roots may be left un-extracted in order to better protect developing teeth beneath them, or due to complication of the procedure.
- The use of Nitrous oxide gas can have the side effect of nausea or vomiting. Avoiding large meals before use of Nitrous can help decrease this risk.

As a Legal Guardian of my child I hereby state that I have read and understand this consent, and that all questions about the procedures have been answered to my satisfaction. I understand that I have the right to be provided with the answers to questions that may arise during the course of my child's treatment. I further understand that this consent will remain in effect until I choose to terminate it.

Patient's Name _____ Signature of Parent or Legal Guardian _____ Date _____

Acknowledgment of Receipt of Privacy Practices and Consent for Use of Health Information

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices as provided in the office and on our website. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature of Responsible Party / Parent or Legal Guardian _____ Date _____

OUR OFFICE IS HIPPA AND OSHA COMPLIANT AND FOLLOWS THE BEST PRACTICES FOR STERILIZATION AND INFECTION CONTROL AS OUTLINED BY THE CDC

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
❑ Communications barriers prohibited obtaining the acknowledgement
❑ An emergency situation prevented us from obtaining acknowledgement
❑ Other _____