



Par-La-Ville Dental

14 Par-La-Ville Place
Hamilton, HM 08
Tel: 441.296.0011 • Fax: 441.296.3019
parlavedental@gmail.com
www.parlavedental.bm

CHILD PATIENT FORM

About Your Child

Child's name _____

Name child prefers to be called _____

Age _____ Male Female Date of birth _____

Address _____

Home phone _____ Patient's school _____

Child's cell phone _____

Grade level _____

Other children and their ages _____

Referred to our office by (we wish to thank them) _____

Primary Care Giver: Mother Father Other

Dental History

Is your child experiencing dental discomfort? Yes No

Does your child play any sports? Yes No

Do you expect your child to be a cooperative patient?
If no, please explain. Yes No

Has your child had a history of headaches, pain,
popping or clicking of the jaws? Yes No

Does your child still have a night time bottle? Yes No

Does your child have a toothache? Yes No

Does your child have or has he or she had any of the following problems or habits?

Grinds teeth How long? _____ Still active Yes No

Thumb sucking How long? _____ Still active Yes No

Finger habit How long? _____ Still active Yes No

Pacifier How long? _____ Still active Yes No

Bottle habit How long? _____ Still active Yes No

Medical History

Are your child's immunization up to date? Yes No

Paediatricians name: _____

Address: _____

Phone number: _____

• Has your child had past ear infections? Yes No

• Have your child's tonsils and/or adenoids been removed? Yes No

• Does your child have any drug allergies? If yes, explain Yes No

• Does your child have any food allergies? If yes, explain Yes No

• Does your child carry an epipen? Yes No

• Is your child taking any medications at this time? If yes, list Yes No

• Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? Yes No

• Has your child had general anesthesia? Yes No

• Does your child need to take antibiotics before dental treatment? Yes No

• Does your child snore? Yes No

Please indicate if your child has had any of the following:

- | | |
|--|--|
| <input type="checkbox"/> Allergy to Penicillin | <input type="checkbox"/> Intellectual disability |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Latex allergy/sensitivity |
| <input type="checkbox"/> Autism/Asperger's Syndrome | <input type="checkbox"/> Liver problems or hepatitis |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Malignancies or leukemia |
| <input type="checkbox"/> G6PD | <input type="checkbox"/> Other drug allergy |
| <input type="checkbox"/> Cleft palate | <input type="checkbox"/> Physical handicap |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Positive for H.I.V. |
| <input type="checkbox"/> Endocrine disorder | <input type="checkbox"/> Food allergy |
| <input type="checkbox"/> Epilepsy, seizures | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Hyperactivity/ADD/ADHD | <input type="checkbox"/> Speech problem |
| <input type="checkbox"/> Heart ailment or murmur. Type, if known _____ | |

Is child under the care of a cardiologist or special physician for the problem?

If so, whom _____

Phone: _____

Please comment on any problems that were checked in the above areas

Responsible Party

Responsible party: Father Mother Other

Insured Under: Father Mother (please tick as appropriate)

Father's full name _____

Address _____

_____ Birth date _____

Home phone _____ Cell phone _____

Business phone _____ Employer _____

Occupation _____ Email address _____

Dental insurance: Yes No Insurance company _____

Group or plan number _____

Certificate # _____

Mother's full name _____

Address _____

_____ Birth date _____

Home phone _____ Cell phone _____

Business phone _____ Employer _____

Occupation _____ Email address _____

Dental insurance: Yes No Insurance company _____

Group or plan number _____

Certificate # _____

Financial Information

I/We accept responsibility for payment of services rendered for

Name: _____

I hereby give Par-La-Ville Dental authorization to charge the following Credit card for any outstanding uninsured portion:

Credit card number: _____

Expiry date: _____

- Payment is expected at time of treatment.
- All emergency patients (being seen for the first time) are required to pay in full at time of treatment.
- Patients with insurance must pay their estimated portion, including deductible, at the time of service.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I hereby authorize payment directly to Par-La-Ville Dental, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

SIGNED (Guarantor)

Permission to Treat

I (We) _____
print name(s) of legal guardian(s)

authorize Par-La-Ville Dental and its personnel to deliver dental services to my child. Using proper and acceptable methods to complete the same

Topical Fluoride Yes No

Sealants Yes No

X-rays Yes No

Nitrous Oxide Yes No

Voice control Yes No

Protective stabilization Yes No

I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

SIGNED (parent or legal guardian)

DATE



INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES AND DENTAL TREATMENT

This office provides our prospective patients with information regarding the treatment or procedures that they are contemplating. We also wish to obtain your consent for any specific dental procedures or techniques which might be of concern to patient or parent. Informed consent indicates your awareness of sufficient information to allow you to make an informed personal choice concerning your child's dental treatment after considering the risks, benefits and alternatives.

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. The behavior management techniques used in this office are as follows:

- 1. Tell-Show-Do:** The dentist, hygienist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is done by demonstrating with instruments on a model, the dentist's finger or the child's finger. The procedure is then 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 or a prize. It is left to the dentist's discretion if the child is rewarded with a prize at the end of their visit, in order to reinforce that uncooperative behavior is not tolerated in this office. A visit to the dental office does not guarantee a reward in the form of a prize.
- 3. Voice Control:** The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command. Parents are reminded that if voice control is used on their child, the dentist, hygienist or assistant is not angry with their child, but is using a technique to gain their child's attention.
- 4. Protective stabilization:** This is a method to immobilize or reduce the ability of a patient to move his or her arms, legs, body or head freely. There are a variety of forms and levels. For instance, if a pediatric dentist uses active immobilization, she might ask the parent to hold the child in their lap and use their arms to hug and stabilize the child. If a pediatric dentist uses passive stabilization, she might use a "wrap" or "blanket" to stabilize the child's arms and legs, similar to the way a car seat stabilizes a child in a moving vehicle. Because every child is different, a wide range of choices exist and pediatric dentists always choose the least restrictive method that is appropriate and best for each patient.
- 5. Parent/Guardian in the Treatment Room:** Parents/Guardians are permitted to be with their child during the first cleaning or exam appointment; however, at each subsequent appointment, we ask that the parent/guardian retreat to the lobby area until their child's treatment has been completed. Our intentions are to establish a rapport with your child, to give them our full attention, to gain their confidence and help them overcome apprehension. Also, the doctor may be performing an invasive procedure, such as a filling, and minimal movement, conversation and distraction in and around the operative area are crucial for focus and optimal care of our patients. There may be circumstances that require a parent/guardian to be present. This will be done on a case-by-case basis. We thank you for your cooperation and support.

The listed pediatric dentistry behavior techniques are understood and I hereby authorize and direct Dr. Brown and/or dental auxiliaries of their choice to utilize the behavior modification techniques listed. Sedation (nitrous oxide) will only be used after a thorough discussion with me to ensure that this is the appropriate manner in which to treat my child. Many routine dental procedures do not require sedation and, if necessary due to behavior and/or dental procedure, Dr. Brown will discuss with me their recommendation. However, if I feel it is necessary to sedate my child for a procedure that I think/know will be difficult for them (although sedation may not be a routine procedure for children of a particular age and/or dental procedure and although my child's behavior appears cooperative to the dentist), I MUST notify the dentist BEFORE the procedure begins, otherwise, the treatment will be rendered per the dentists recommendations.

Parent/Guardian Initials

After careful examination of your child, Dr. Brown will provide you with a proposed treatment plan (if treatment is needed following an examination and/or cleaning and radiographs) for your child with the understanding that dental treatment may/can change depending on several factors, such as, but not limited to: behavior, timely kept appointments, x-rays and growth and development. **Although this consent is usually signed at the first dental appointment, giving consent today allows for future exams, necessary check-ups and cleanings for future visits.**

I hereby acknowledge that I have read, agree to and understand this consent and that all questions about the behavior management techniques described have been answered in a satisfactory manner and I further understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment.

I further understand that this consent shall remain in effect until terminated by me. A scanned copy of this consent shall serve as the original. I also understand that by signing this consent once, it shall be in effect for every future dental appointment at this office, although treatment may be added/changed. **Please sign below giving consent to examine your child which may include some or all of the following procedures including above mentioned behavioral techniques: Initial examination including but not limited to: scaling, prophylaxis, fluoride and necessary radiographs, sealants.**

Parent/Guardian Printed Name _____ Date: _____

Parent/Guardian Signature _____