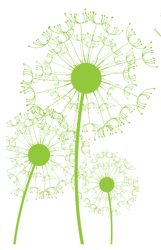


Par-La-Ville Dental

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

CHILD PATIENT FORM

About Your Child

Child's name ______________________________

Name child prefers to be called ______________________________

Age ______________ Gender ______________

Pronouns ______________ Date of birth ______________

Patient's school ______________________________

Child's cell phone (if over 16 years) ______________________________

Other children and their ages ______________________________

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

____

____

Dental History

Is your child experiencing dental discomfort/toothache? ❒ Yes ❒ No

Does your child play any sports? ❒ Yes ❒ No

Does your child have a dental/medical phobia? ❒ Yes ❒ No

Does your child have past traumatic dental experiences? ❒ Yes ❒ No

Has your child had a history of headaches, pain, T.M.J. popping or clicking of the jaws? ❒ Yes ❒ No

Does your child snore? ❒ 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? ❒ Yes ❒ No
  If yes, explain

____

____

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

____

____

- Does your child carry an Epipen? ❒ Yes ❒ No
- Is your child taking any medications at this time? ❒ Yes ❒ No
  If yes, list

____

____

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

____

____

- Has your child had general anesthesia? ❒ Yes ❒ No
- Does your child need to take antibiotics before dental treatment? ❒ Yes ❒ No

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

❒ Allergy to Drugs
❒ Allergy to Food
❒ Asthma
❒ Autism/Spectrum Disorder
❒ Bleeding disorder
❒ G6PD
❒ Cancer
❒ Cleft palate
❒ Covid-19
❒ Diabetes
❒ Special Needs
❒ Endocrine disorder
❒ Epilepsy, seizures
❒ Hyperactivity/ADHD/ADD
❒ Hearing Impaired
❒ Intellectual differences
❒ Latex allergy/sensitivity
❒ Liver problems or hepatitis
❒ Rheumatic fever
❒ Speech Impediment
❒ Heart ailment or murmur. Type if Known ______________________________

Is child under the care of a cardiologist or special physician for the problem? ❒ Yes ❒ No

If so, whom ______________________________

Phone: ______________________________

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

____

____

Caregiver Contact Information

Primary Caregiver ______________________

Relationship to Child ______________________

Address ______________________

____

Birth date ____________ Home phone ____________

Cell phone ____________ Business phone ____________

Email address ______________________

Additional Caregiver ______________________

Relationship to Child ______________________

Address *(if different from above)* ______________________

____

Birth date ____________ Home phone ____________

Cell phone ____________ Business phone ____________

Email address ______________________

Health Insurance Information

Health Insurance Company______________________

Group/Plan number______________________

Certificate #______________________

Employer ______________________

Named of Insured______________________

Date of Birth ______________________

Financial Responsibility

I/We accept responsibility for payment of services rendered for

Name: ______________________

Address *(if different from Caregiver)* ______________________

____

Phone: ____________ **Email:** ______________________

- 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.

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

____

Credit card number:______________________

Expiry date: ______________________

____

SIGNED (Guarantor)

Permission to Treat

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

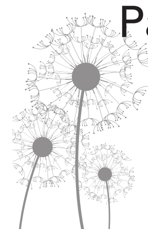
authorize Par-La-Ville Dental and its personnel to deliver dental services to my child. Using proper and acceptable methods to complete the same

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**



Par-La-Ville Dental

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

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 denial 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: <u>Initial examination including but not limited to: scaling, prophy, fluoride and necessary radiographs, sealants.</u>**

Parent/Guardian Printed Name ____ **Date:** ______________________

Parent/Guardian Signature ____