VITAL SMILES
DENTAL & ORTHODONTICS

PATIENT INFORMATION

PATIENT NAME | DATE OF BIRTH | AGE | MALE OR FEMALE

SSN# | SCHOOL | GRADE | PHYSICIAN'S NAME

PARENT/GUARDIAN NAME(S) | HOW DID YOU HEAR ABOUT US?

STREET ADDRESS | CITY | STATE | ZIP CODE

(_____) HOME PHONE | (_____) WORK PHONE | (_____) CELL PHONE | EMAIL ADDRESS

NEAREST RELATIVE NOT LIVING WITH PATIENT | RELATIONSHIP TO PATIENT | (_____) PHONE

PLEASE LIST OTHER SIBLINGS SEEN AT VITAL SMILES:_____

PATIENT HEALTH HISTORY *(Check **Y**es or **N**o)*

	Y	N
HEART TROUBLE	☐	☐
ULCER	☐	☐
PREGNANT	☐	☐
HEPATITIS	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ALLERGIES	☐	☐
TUBERCULOSIS	☐	☐
CEREBRAL PALSY	☐	☐

	Y	N
ANEMIA	☐	☐
ASTHMA	☐	☐
DIABETES	☐	☐
BLEEDING	☐	☐
HIV/AIDS	☐	☐
AUTISM	☐	☐
PROSTHETIC JOINTS/PINS	☐	☐
OTHER:_____	☐	☐

IF YOU HAVE ANSWERED "YES" TO ANY OF THE ABOVE, PLEASE EXPLAIN:_____

HAS THE PATIENT EVER BEEN TREATED IN THE EMERGENCY ROOM? YES ☐ NO ☐

IF "YES", PLEASE LIST DATE(S) AND EXPLAIN:_____

HAS THE PATIENT EVER BEEN HOSPITALIZED? YES ☐ NO ☐

IF "YES", PLEASE LIST DATE(S) AND EXPLAIN:_____

HAS THE PATIENT EVER HAD ANY SURGERIES? YES ☐ NO ☐

IF "YES", PLEASE LIST DATE(S) AND EXPLAIN:_____

IS THE PATIENT TAKING ANY MEDICATIONS AT THIS TIME? YES ☐ NO ☐

IF "YES", WHAT KIND AND WHAT FOR_____

IS THE PATIENT ALLERGIC TO MATERJALS COMMONLY USED IN A DENTAL OFFICE (I.E. LATEX GLOVES, ANESTHESIA) YES ☐ NO ☐

IF "YES", PLEASE INDICATE:_____

IS THE PATIENT ALLERGIC TO ANY MEDICATIONS?_____

ANY DENTAL PROBLEMS/CONCERNS AT THIS TIME? PLEASE EXPLAIN: _____

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE. I ACKNOWLEDGE THAT MY QUESTIONS REGARDING THE INQUIRIES SET FORTH HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD THE DENTIST OR ANY MEMBERS OF H1S/HER STAFF RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM. I HAVE READ AND UNDERSTAND THE PEDIATRIC DENTISTRY PATIENT MANAGEMENT TECHNIQUES AND GIVE MY CONSENT FOR THEIR USES. I ALSO GIVE CONSENT FOR THE DENTIST AND HIS/HER STAFF TO TREAT MYSELF AND/OR MY CHILD.

_____

PARENT/GUARDIAN SIGNUATURE

I HAVE REVIEWED THE ABOVE PATIENT'S INFORMATION AND MEDICAL HISTORY IN IT'S ENTIRETY.

FRONT DESK INITIALS | HYGIENIST INITIALS | DENTIST SIGNATURE | DATE

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its' *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request, in writing, that you restrict how private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

PATIENT NAME _____ RELATIONSHIP TO PATIENT _____

DATE _____ SIGNATURE _____

VITAL SMILES POLICY REGARDING APPOINTMENTS

Vital Smiles is here to serve children that have Medicaid, Blue Cross and other federally subsidized insurance plans. Because of the great demand for these services, our time is very valuable, and we have found it necessary to implement some policies regarding our appointment times. If the parent or legal guardian of the patient does not call or reschedule an appointment at least 24-hours ahead of time it will count as a BROKEN APPOINTMENT. After three (3) NO SHOWS or BROKEN APPOINTMENTS you will lose your appointment privileges. Your child may be seen as a walk-in. You may come to the office between 8:00am-8:30am or l:00pm-1:30pm. We will work your child into the schedule. Thank you for helping us serve all our patients in a timely manner.

I understand and agree to the policies explained to me in the above statement.

SIGNATURE _____ DATE _____

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IT IS OUR INTENT THAT ALL PROFESSIONAL CARE DELIVERED IN OUR DENT AL OPERATIONS SHALL BE OF THE BEST POSSIBLE QUALITY THAT WE CAI\ PROVIDE FOR EACH CHILD; PROVIDING A HIGH QUALITY OF CARE CAN SOMETIMES BE MADE VERY DIFFICULT, OR EVEN IMPOSSIBLE, BECAUSE OF THE LACK OF COOPERATION OF SOME PA TIEJIITS. AMONG THE BERA VIOR THAT CAN INTERFERE WITH THE PROPER PROVISION OF QUALITY DENTAL CARE ARE: HYPERACTIVITY, RESISTIVE MOVEMENTS, REFUSINGTO OPEN MOUTH/KEEP OPEN LONG ENOUGH TO PERFORM THE NECESSARY DENTAL TREATMENT, AND EVEN AGGRESSIVE AND/OR PHYSICAL RESISTANCE TO TREATMENT, SUCH AS KICKING, SCREAMING, AND GRABBING AT THE DENTIST'S HAND OR THE SHARP INSTRUMENTS. ALL EFFORTS WLL BE MADE TO OBTAIN THE COOPERATION OF CHILD DENTAL PATIENTS BY THE USE OF WARMTH, FRIENDLINESS, PERSUASION, HUMOR, CHARM, GENTLENESS, KINDNESS, AND UNDERSTANDING.

METHODS USED:

1. TELL/SHOW/DO: THE DENTIST OR ASSISTANT EXPLAINS TO THE CHILD WHAT IS TO BE DONE USING SIMPLE TERMINOLOGY AND REPETITION AND THEN SHOW THE CHILD WHAT IS TO BE DONE BY DEMONSTRATING WITH INSTRUMENTS ON A MODEL OR THE CHILD'S/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, AND A PRIZE.

3. VOICE CONTROL: CHANGING THE TONE OR INCREASING THE VOLUME OF THE DENTIST'S VOICE GAINS THE ATTENTION OF A DISRUPTIVE CHILD. CONTENT OF THE CONVERSATION IS LESS IMPORTANT THAN THE ABRUPT OR SUDDEN NATURE OF THE COMMAND.

4. MOUTH PROPS: A RUBBER OR PLASTIC DEVICE IS PLACED IN THE CHILD'S MOUTH TO PREVENT CLOSING WHEN A CHILD REFUSES OR HAS DIFFICULTY MAINTAINING AN OPEN MOUTH.

5. PHYSICAL RESTRAINT BY THE DENTIST: THE DENTIST RESTRAINS THE CHILD FROM MOVEMENT BY HOLDING DOWN THE CHILD'S HAND OR UPPER BODY, STABILIZING THE CHILD'S HEAD BETWEEN THE DENTIST ARM AND BODY, OR POSITIONING THE CHILD FIRMLY IN THE DENT AL CHAIR.

6. PHYSICAL RESTRAINT BY THE ASSISTANT: THE ASSISTANT RESTRAINS THE CHILD FROM MOVEMENT BY HOLDING THE CHILD'S HAND, STABILIZING THE HEAD, AND/OR CONTROLLING LEG MOVEMEMENTS.

7. PAPOOSE BOARDS AND PEDO- WRAPS: THESE ARE RESTRAINING DEVICES FOR LIMITING THE DISRUPTIVE CHILD'S MOVEMENT TO PREVENT INJURY AND TO ENABLE THE DENTIST TO PROVIDE THE NECESSARY TREATMENT. THE CHILD IS WRAPPED IN THE DEVICE AND PLACED IN A RECLINED DENTAL CHAIR.

8. NITROUS OXIDE: NITROUS OXIDE MAY BE PROVIDED FOR YOUR CHILD. THE PATIENT DOES NOT BECOME UNCONSCIOUS.

NOTE: IF YOU DO NOT AGREE WITH THE ABOVE METHODS LISTED, PLEASE LET US KNOW SO THAT WE MAY SPEAK TO YOU ABOUT THEM. HOWEVER, PLEASE REALIZE THAT IT MAY NOT BE POSSIBLE TO COMPLETE ANY DENTAL WORK FOR YOUR CHILD IN A SAFE ENVIRONMENT.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THE PEDIATRIC DENTISTRY PATIENT MANAGEMENT TECHNIQUES AND GIVE MY CONSENT FOR THEIR USES.

SIGNATURE _____ DATE _____