oceanview dental care

# Pediatric Patient Registration & Health History

905 Calle Amanecer, Suite 265
San Clemente, CA 92673
(949) 388-0780
OceanViewDentist.com
*General & Cosmetic Dentistry*

Patient Name: _____ Birthdate: _____ Parent Email: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Parent 1:_____ Birthdate: _____ Cell Phone: _____

Employer: _____ City: _____ Social Security Number: _____

Parent 2: _____ Birthdate: _____ Cell Phone: _____

Employer: _____ City: _____ Social Security Number: _____

Person Responsible for this Account: _____ Relation to Patient: _____ Dental Insurance? ❑ Yes ❑ No

**How did you hear about our office?** ❑ Yelp ❑ Google ❑ Mailer ❑ Referral _____ ❑ Other _____

## Dental Information

What prompted you to seek dental care at this time for your child?

_____

When was your child's last visit to a dentist? _____

What was done at their last visit? _____

_____

Why are you changing dentists? _____

Has the fear of discomfort kept your child from regular dental visits? ❑ Yes ❑ No

Has your child lost any teeth prematurely? ❑ Yes ❑ No

Are any of your child's teeth sensitive to: ❑ Heat ❑ Cold ❑ Biting Pressure

Has your child had braces or any orthodontic treatment? ❑ Yes ❑ No

Are you concerned about the appearance of your child's teeth for any reason? ❑ Yes ❑ No

Does your child brush their own teeth? ❑ Yes ❑ No

How often does your child brush their teeth? _____

Does your child use dental floss? ❑ Yes ❑ No

Does your child's gums bleed when brushing or flossing? ❑ Yes ❑ No

Have you been told your child has Periodontal/Gum Disease? ❑ Yes ❑ No

Are you aware of any swelling or lump in your child's mouth? ❑ Yes ❑ No

Does your child grind or clench their teeth? ❑ Yes ❑ No

Are you aware of their jaw clicking or making grating-like noises? ❑Yes ❑No

Has your child ever had TMJ treatments? ❑ Yes ❑ No

**CONSENT:** The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of dental needs. I also authorize Doctor to perform all recommended treatment agreed by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk including, but not limited to paresthesia and allergic reactions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a monthly 1.5% finance charge (18% APR) or $4 rebilling fee, whichever is greater, may be added to my account. In the case of default of payment, I will additionally pay any collection costs and reasonable attorney fees incurred to effect collection on this account.

Guardian Signature: _____ Date: _____

**OVER →**

# Pediatric Medical History

Patient Name: _____

Child's Physician's Name: _____ City: _____ Phone: (_____) _____

Preferred Pharmacy Information: _____ City: _____ Phone: (_____) _____

## Has your child had or currently have any of the following conditions?

| | Yes | No | | Yes | No | | Yes | No | | Yes | No |
|---|---|---|---|---|---|---|---|---|---|---|---|
| High Blood Pressure | ❑ | ❑ | Hepatitis | ❑ | ❑ | Dry Mouth | ❑ | ❑ | Kidney Trouble | ❑ | ❑ |
| Autism Spectrum Disorder | ❑ | ❑ | Stroke | ❑ | ❑ | Liver Disease | ❑ | ❑ | Radiation Therapy | ❑ | ❑ |
| Heart Murmur | ❑ | ❑ | Heart Disease or Attack | ❑ | ❑ | Fainting or Dizzy Spells | ❑ | ❑ | Chemotherapy | ❑ | ❑ |
| Mitral Valve Prolapse | ❑ | ❑ | Diabetes | ❑ | ❑ | Heart Surgery | ❑ | ❑ | Psychiatric Care | ❑ | ❑ |
| ADD/ADHD | ❑ | ❑ | Tuberculosis | ❑ | ❑ | Hemophilia | ❑ | ❑ | AIDS or HIV Positive | ❑ | ❑ |
| Artificial Heart Valve | ❑ | ❑ | Artificial Joints (Hip, Knee) | ❑ | ❑ | Asthma | ❑ | ❑ | Drug Addiction | ❑ | ❑ |
| Heart Pacemaker | ❑ | ❑ | Arthritis | ❑ | ❑ | Thyroid Disease | ❑ | ❑ | Mental, Emotional, or Developmental delay | ❑ | ❑ |

Has your child ever had surgery? ❑ Yes ❑ No If yes, list all past surgical procedures. _____

_____

Does your child have any disease, problem, or condition not listed? ❑ Yes ❑ No If Yes, what? _____

Has your child been under the care of a Physician in the last 2 years? ❑ Yes ❑ No If Yes, for? _____

Is your child currently under the care of a Physician? ❑ Yes ❑ No If Yes, why? _____

Has your child ever been hospitalized? ❑ Yes ❑ No If Yes, why? _____

Is your child currently taking any medication, drugs, pills, or vitamins? ❑ Yes ❑ No If Yes, what? Please list below:

_____ _____

_____ _____

Does your child have an allergy to local anesthetic? ❑ Yes ❑ No If Yes, what? _____

Does your child have an allergy to any other medication(s)? ❑ Yes ❑ No If Yes, what? _____

Does your child have an allergy to latex / rubber products/ metals? ❑ Yes ❑ No If Yes, what? _____

Has your child ever had a prescription for Bisphosphonate (Fosmax)? ❑ Yes ❑ No

Does your child use tobacco products (including vaping devices)? ❑ Yes ❑ No

**FOR FEMALE ONLY:** Is your daughter pregnant? ❑ Yes ❑ No Is your daughter taking Birth Control Pills? ❑ Yes ❑ No

Nearest Relative not living with you: _____ Relation: _____ Phone: (_____) _____

**THE ABOVE INFORMATION IS TRUE:** To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my Physician to be contracted for details and advice.

X_____ X_____ _____

Patient or Guardian Signature | Provider (Dentist/Hygienist) Signature | Date

**(For Office Use Only) Medical History Review**: I have reviewed this medical history and have added any changes since my last review.

| | | |
|---|---|---|
| Initial: _____ Date: _____ | Initial: _____ Date: _____ | Initial: _____ Date: _____ |
| Dr./Hygienist Initial: _____ | Dr./Hygienist Initial: _____ | Dr./Hygienist Initial: _____ |

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# Pediatric Risk Assessment
## Sleep Disordered Breathing & Airway Obstruction

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The latest biomedical research is uncovering the link between sleep-related breathing disorders (SRBD) and our overall health. The American Dental Association (ADA) Council on Dental Practice made a Policy Statement emphasizing the important role dental professionals play in screening and either treating or referring for sleep, breathing and airway related disorders. **In compliance with ADA's position statement, we are providing this screening questionnaire to our patients.**

**Did you know that:**

- Obstructive Sleep Apnea may reduce a child's IQ for the rest of their life.
- Airway obstruction is linked to ADHD, learning disabilities, behavior issues, anxiety, aggression, allergies, asthma, and chronic inflammation.

**Does your child: (check all that apply)**

*Yes= 1 point, No= 0 points*

- ❑ Snore while sleeping?
- ❑ Mouth-breathe while awake or sleeping?
- ❑ Breathe audibly/noisily while awake or sleeping?
- ❑ Ever gasp or wake with a startle?
- ❑ Appear to stop breathing when sleeping?
- ❑ Have nightmares?
- ❑ Wet the bed?
- ❑ Grind their teeth at night?
- ❑ Sleep in odd positions or with their head extended back?
- ❑ Toss, turn, thrash, or seem restless during sleep?
- ❑ Wake frequently in the night?
- ❑ Experience chronic nasal discharge/runny nose or congestion?
- ❑ Have recurrent ear infections?
- ❑ Appear tired during the day?
- ❑ Show visible dark circles under their eyes?
- ❑ Struggle with performance in school or have a lack of focus?
- ❑ Wake up with a headache?
- ❑ Suck their thumb, finger(s), or use a pacifier?
- ❑ Exhibit behaviors such as ADD/ADHD tendencies, oppositional/defiant behaviors, tantrums, anxiety, or depression?

**Scoring:**
0-2: Low suspicion of Sleep Disordered Breathing/Airway Obstruction
3-4: Moderate suspicion of Sleep Disordered Breathing/Airway Obstruction
5+: High suspicion of Sleep Disordered Breathing/Airway Obstruction

Patient or Guardian Signature: _____ Date:_____

**(For Office Use Only) Medical History Review**: I have reviewed this medical history and have added any changes since my last review.

| | | |
|---|---|---|
| Initial: _____ Date: _____<br>Dr./Hygienist Initial:_____ | Initial: _____ Date: _____<br>Dr./Hygienist Initial: _____ | Initial: _____ Date: _____<br>Dr./Hygienist Initial:_____ |

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# Consent for services, Financial Policy, & Truth-in-Lending Statement

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The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of dental needs. I also authorize Doctor to perform all recommended treatment agreed by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk including, but not limited to paresthesia and allergic reactions.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services and any dental services performed without previous financial arrangements must be paid for in cash at the time services are rendered.

Patients who carry dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies, and will credit any collections from insurance to the patient's account. This dental office cannot render services on the assumption that the resulting charges will be covered by insurance.

I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a monthly 1.5% finance charge (18% APR) or $4 rebilling fee, whichever is greater, may be added to my account. In the case of default of payment, I will additionally pay any collection costs and reasonable attorney fees incurred to effect collection on this account. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I understand that the fee estimates for dental care can only be extended for a period of six months from the date of consultation.

Please sign to consent to these terms.

Guardian Signature: _____ Date: _____


# HIPPA Acknowledgement

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I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

Information sharing: Please list any individuals we can share your personal information with other than healthcare providers. If none then please write NONE.

_____

Please sign to consent to these terms.

Guardian Signature: _____ Date:_____

# Appointment Cancellation Policy Agreement

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Ocean View Dental Care is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen. Please call us at (949) 388-0780 at least 24-hours prior to your scheduled appointment to notify us of any changes or cancellations. If prior notification is not given, you may be subject to a $75 charge for the missed appointment.

Please sign to consent to these terms.

Guardian Signature: _____ Date:_____

# Consent for Internet Communications

905 Calle Amanecer, Suite 265
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I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

Please sign to consent to these terms.

Guardian Signature: _____ Date: _____