MASON PARK FAMILY DENTAL

Please fill out form completely as it is of great value in treating your child. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

DATE: ______________________

PATIENT INFORMATION

Name of Minor/Child ____
Last Name / First Name / Initial

Sex ☐ M ☐ F Age _______ Birthdate ___________ Nickname ____________________

Home Address ____
Street / City / State / Zip

Mailing Address ____
Street / City / State / Zip

Person Financially Responsible _______________ Home Phone _____________ Work Phone ___________

Whom may we thank for referring you? ____

MOTHER/GUARDIAN INFORMATION

Name ____
Last Name / First Name / Initial

Relationship to Patient ____

Address (if different) ____
Street / City / State / Zip

Home # _____________ Work # _____________ Cell# _____________ Other # ___________

Soc Sec # ______________________ Birthday ______________________

Do you have insurance coverage for the child? Y or N

Employer _________________ Occupation _____________ # Yrs There____ Work # ___________

Plan Name ______________________ Plan Number ______________________

Address ____
Street / City / State / Zip

Group # ______________________ Policy # ______________________

FATHER/ GUARDIAN INFORMATION

Name ____
Last Name / First Name / Initial

Relationship to Patient ____

Address (if different) ____
Street / City / State / Zip

Home # _____________ Work # _____________ Cell# _____________ Other # ___________

Soc. Sec # ______________________ Birthday ______________________

Do you have insurance coverage for the child? Y or N

Employer _________________ Occupation _____________ # Yrs There____ Work # ___________

Plan Name ______________________ Plan Number ______________________

Address ____
Street / City / State / Zip

Group # ______________________ Policy # ______________________

Email address: ______________________

MEDICAL HISTORY

Minor/Child's Physician ______________________ City/State ______________ Phone ________________

Date of last physical exam ____________________ Results ________________________________

Is child under care of physician now? Y or N Medications ________________________

Receiving any medications or drugs? Y or N ________________________

Ever been hospitalized? Y or N ________________________

Ever had surgery? Y or N Allergy ________________________

Is there excessive bleeding when cut? Y or N ________________________

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING?

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Surgery
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	
☐ Cancer	☐ Drug/Alcohol	☐ Hepatitis	☐ Mumps	
☐ Rhuematic Fever	☐ Sinus Problems	☐ Thyroid Disease	☐ Other	

Explain any above ____

Special needs or problems ____

Parent/Guardian Signature ____

DENTAL HISTORY

Reason for today's dental visit ____

Has your child previously been to a dentist? ______________ Date of last visit ________________

Date of last: Cleaning ______________ Xrays ______________

Has your child previously been to an orthodontist? Y or N Orthodontist's Name ________________

Does your child currently use a: Pacifier? Y or N Bottle? Y or N Suck Finger/Thumb Y or N

Does child brush teeth daily? Y or N Floss daily? Y or N

Does child eat between meals? Y or N Eat many sweets? Y or N

Does child eat balanced meals? Y or N Have food allergies? Y or N

Does child use any fluorides? Y or N Have a special diet? Y or N

Is there now or has there ever been any of the following: (Circle all that apply)

Dental or oral pain Toothache Oral Habits Cavities

Teeth straightened Gum infection Injured teeth Extracted teeth

Unfavorable dental experience

Because your child is a minor it is necessary that signed permission is obtained from a parent or a guardian. The signature below authorizes examination, and treatment if necessary, from the office of Glen R. Ginter, DDS, Inc. and further the use of procedures that the doctor deems necessary during the performance of any dental service.

Furthermore, the undersigned accepts responsibility for any financial obligations incurred for dental treatment of this patient. It is understood that fees for dental services shall be paid at the time services are rendered unless other arrangements have been made in advance.

Signature ______________ Printed Name ____________________ Date ______________

INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent to any specific dental treatment or techniques which may be of concern to the parent, guardian, or patient. Informed consent refers to your awareness of sufficient information to allow you to make informed personal choices concerning dental treatment after considering the risks, benefits, and alternatives. This form discusses the techniques, common to pediatric dentists, which are used in our office. Parents are free to refuse techniques they do not like, and request techniques they prefer. We strive to provide the highest quality of care to our patients. In an ideal scenario, a patient undergoing treatment will remain still and follow the doctor's instructions. With children, the ideal scenario is not always possible. Obtaining a reasonable level of cooperation often requires special patient management techniques. The level of cooperation achieved has a direct impact on the long-term success of the procedure and the aesthetic appeal of the treatment. In the dentist's professional judgment the presence of the parent or guardian in the treatment room is likely to have an adverse effect on the treatment of the child. You are being informed our policy does not allow parents in the room with child. Risk factors can consist but not limited to minor bruises and scratches, but fewer injuries were incurred due to passive stabilization compared to active stabilization. Patients placed on a rigid stabilization board may overheat during the dental procedure. Significant release of adrenal catecholamines may exist in patients who are experiencing increased agitation when restrained or protective stabilization equipment. Excessive catecholamine release may sensitize the heart and cause rhythm disturbances. Benefits consist with but not limited to are the ethical obligation to do well, to achieve the maximize benefits of quality care in dental treatment and minimize risk of injury during treatment the patient and dental staff. Additionally, uncooperative patients can injure themselves, the doctor, and the assistants. These factors:

- Tell-Show-Do: The dentist, hygienist or assistant explains to the child what is to be done using simple terminology and repetition. Demonstrations are performed on a model or the child's finger. Then the procedure is performed in the child's mouth as described.
- Positive reinforcement: The child is rewarded for displaying any beneficial behavior. Rewards can be compliments, praise, or a prize.
- Voice Control: The attention of a disruptive child is gained by changing the tone of the dentist's or assistant's voice.
- Mouth Prop: A rubber or plastic device is placed in the child's mouth to prevent it from closing when a child refuses to open or has difficulty maintaining an open mouth.
- Passive Restraint: A wrist restraints and or leg blanket used to keep the patient from making potentially dangerous, disruptive movements to enable the doctor to complete the necessary treatment.
- Passive Restraint: A papoose blanket is used to keep the patient from making potentially dangerous, disruptive movements to enable the doctor to complete the necessary treatment.
- Active Restraint: The dentist, assistant, or parent holds the child's head, hands, and/or legs to keep them from injuring themselves or others.
- Sedation: Medication can be administered by inhalation, orally, or by injection to relax a child who does not respond to other behavior management techniques. This can be at mild, moderate, or deep levels.

I have read and understand the above, and had all questions answered to my satisfaction. I further understand that this consent shall remain in effect until terminated by me in writing.

Patient's name: ______________________________

Signature ______________________________

If patient is a child ***Signature** of person authorized to make dental care decisions for the Child:

Relationship to the child: ____________________ Date: ____________________

Consent for Dental Treatment

The permission of a parent or guardian is required before a minor can receive dental treatment. I hereby give permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE:____

Relationship: ____________________ Date:___________

Financial and Appointment Agreement

As a courtesy to our patients, we agree to bill your insurance company. The guarantor, however, is ultimately responsible for all balances due. The patient hereby assigns benefits to be paid directly to this provider by all of their third party payors. The patient authorizes this office to release any information required by a third party payor necessary for reimbursement of charges incurred. Any charges not paid by an insurance company, ninety days from the date of service, will be billed to the guarantor, and payment is due upon receipt of the bill. Any payments made by the insurance company after the ninety day period will be credited to the patient's account. Those credited monies can then either be used towards future treatment, or the guarantor can request that monies be refunded to card used for payment. We will do our best in estimating how much an insurance company will pay towards a treatment plan, and then will present that information to each and every guarantor before scheduling a patient for treatment. These estimates are, by definition, only estimates however, and an adjustment may be necessary once we have been paid by the insurance company for benefits received. By scheduling your child for treatment, you are expressly agreeing that you have been given an estimate of the cost of treatment, and are fully aware of your estimated portion, due and payable upon completion of treatment. Once the estimate is provided to the guarantor, it is the guarantor's responsibility to decide how he or she will pay for the outstanding balance the insurance will not cover at the time of treatment. We accept all major credit and debit cards for your convenience. Our appointment time is valuable; therefore, we require a 48 hour notice in the event a cancellation of a previously scheduled appointment is necessary. The office policy is that a patient and their siblings may be inactivated from the practice should there be two appointments of "no shows" or cancellations with less than 48 hours notice. Anything after 10 minutes of appointment time is considered a missed appointment. Anything less than a 48 hour notice is subject to a FEE. The FEE will need to be paid prior to scheduling any future visits.

SIGNATURE:____

Relationship: ____________________ Date:___________

Acknowledgement of Receipt of Notice of Privacy Practices Section HIPPA

A: The Patient. Name: ________________________________ Age: ___________

Section B: Acknowledgement by Patient or Legal Guardian.

I, __________________________, acknowledge that I have received a Notice of Privacy Practices from Glen R. Ginter DDS, INC aka Mason Park Family Dental aka Dr.Wu, Dr. Mata, Dr.Ginter.

SIGNATURE:____

Relationship to Patient: ________________________________ Date:___________

Section C: To be completed by Staff

Our office made a good faith effort to *obtain an Acknowledgement of Receipt of Notice of Privacy Practices but was unable to obtain it* because:

Patient or legal guardian refused to sign
An emergency kept us from obtaining a signature
Language barriers prevented us from obtaining a signature

Name of Staff Member: __________________ Signature of Staff Member: __________________

Authorization for Non-Parent/Guardian Consent

Our office encourages that all parents or legal guardians accompany their child to each dental appointment. If the parent is unable to accompany the child for their dental appointment or recall visits please fill out this form.

Child(ren) name(s):

____

____

Authorized caregiver's name ____
Relationship to child(ren) ______________________ ______________________
Caregiver's phone number ______________________

Authorized caregiver's name ____
Relationship to child(ren) ______________________ ______________________
Caregiver's phone number ______________________

Authorized caregiver's name ____
Relationship to child(ren) ______________________ ______________________
Caregiver's phone number ______________________

I give permission for the above name caregiver shall be authorized to accompany the above named child(ren) for their initial examinations and subsequent recall visits. Treatment to be performed include routine pediatric dental services (examinations, cleanings, radiographs, fluoride treatment, restorative and/or anything other treatment needed/requested). The initial patient registration package, all medical history/dental history must be filled out by parent or legal guardian.

This consent shall be effective from date of signature until revoked by parent or legal guardian or child reaches 18 years of age.

I can be reached at ____ Phone number

I can be reached at ____ Email

Signature of Parent/Guardian, Date

____

Printed Name of Parent/Guardian

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