Monroe Pediatric Dental Care

Compassionate Dental Care for Kids

1. Patient Information Form

Child's Full Legal Name: _____
Preferred Name/Nickname: _____
Date of Birth: ____ / ____ / ____ Age: _____
Sex: □ Male □ Female □ Other
Home Address: _____
City: _____ State: MI Zip Code: _____
Primary Phone Number: (____) _____-_____
Alternate Phone (Cell/Work): (____) _____-_____
Email Address: _____
Preferred Contact Method: □ Phone □ Text □ Email

2. Parent/Guardian Information

Parent/Guardian #1 Full Name: _____
Relationship to Patient: _____
Address (if different from patient): _____
Employer: _____ Occupation: _____SS#_____
Phone: (____) _____-_____
Email: _____

Parent/Guardian #2 Full Name: _____
Relationship to Patient: _____
Address (if different): _____
Employer: _____ Occupation: _____
Phone: (____) _____-_____
Email: _____

Emergency Contact (Other than Parent)
Name: _____
Relationship: _____ Phone: (____) _____-_____

(Over →)

3. Insurance Information- (Must be completed even if info was given over the phone)

Dental Insurance Carrier: _____
Subscriber/Policy Holder Name: _____
Date of Birth: MM____ / D D____ / Y Y Y Y
Member/Subscriber ID or SS#: _____
Group #: _____
Employer: _____
Insurance Phone #: (____) _____-_____
Is your child covered by a secondary dental insurance? □ Yes □ No
If yes, please provide details:
Secondary Dental Insurance Name: _____
Subscriber Name, DOB and ID#: _____

4. Medical History Questionnaire

Child's Physician Name: _____
Phone: (____) _____-_____
Date of Last Physical Exam: MM____ / D D____ / Y Y Y Y
Is your child currently under a physician's care? □ Yes □ No
If yes, please explain: _____
Is your child currently taking any medications? ⊡ Yes □ No
If yes, list them: _____
Any drug, food, or latex allergies? ⊡ Yes □ No
Please list: _____
Has your child ever been diagnosed or treated for any of the following?
(Please check all that apply)
□ Asthma □ Heart Murmur □ Heart Condition □ Seizures □ Diabetes □ Anemia □ Blood Disorder □ Liver/Kidney Disease
□ ADHD/ADD □ Autism Spectrum Disorder □ Behavioral/Emotional Issues □ Speech Delay □ Hearing Problems□ Developmental Delays □ Learning Disabilities
□ Frequent Ear Infections □ Sleep Apnea □ Allergies/Sinus Issue □ Tuberculosis Exposure
□ Other: _____
□ None of the Above
Does your child have any physical or emotional condition requiring special care?
⊙Yes ❍No
If yes, please explain: _____

5. Dental History

Is this your child's first dental visit? □ Yes □ No
Previous Dentist Name: _____
Date of Last Dental Visit: MM___ / _D D_ / YYYY
What is the reason for today's visit? _____
Does your child:
□ Suck thumb/fingers □ Use pacifier □ Clench/grind teeth □ Bite lips/nails □ Chew on foreign objects □None of these

How often does your child brush their teeth? □ 1x/day □ 2x/day □ Occasionally
Do they floss? □ Yes □ No
Do they use fluoride toothpaste? □ Yes □ No

Has your child had any negative dental experiences? □ Yes □ No
If yes, please explain: _____

How were you referred to our office? _____

6. HIPAA Privacy Notice Acknowledgment

I acknowledge that I have received and reviewed the Notice of Privacy Practices for Monroe Pediatric Dental Care.
I understand that I may request a copy at any time.

□ I authorize Monroe Pediatric Dental Care to discuss my child's health/dental care with the individuals listed below:

_____
_____
_____

Child's Full Name: _____

Parent/Guardian Name: _____
Parent/Guardian Signature: _____
Date: MM___ / _D D_ / YYYY

(Over →)

7. Financial Agreement

I understand that:
- Payment is due at the time services are rendered
- I am responsible for any balance not paid by my insurance provider.
- Returned checks will incur a $35 fee.
- ***A missed appointment with less than 48hr notice will incur a $25 fee***

I have read, understand, and agree to the financial policy.

Parent/Guardian Signature: _____
Date: MM_____ / D D_____ / Y Y Y Y_____

8. Consent for Dental Treatment

I, the undersigned parent or legal guardian, give permission for Monroe Pediatric Dental Care to examine and treat my child.
This may include preventive, diagnostic, restorative, or emergency procedures as deemed necessary by the dentist.
I understand that the dental team will inform me of recommended treatment and will answer any questions.
I also understand that no treatment will be completed without my consent, unless necessary for my child's health and well-being in an emergency.

I attest that all information completed on these forms is true and accurate, including all health history provided.

I also understand that it is my responsibility to keep my children seated while in the building. ***There is no running allowed in the office at any time.***

For the safety and privacy of our patients and staff we do not allow pictures or video to be taken in the office at any time.

Child's Full Name: _____
Parent/Guardian Name_____

Parent/Guardian Signature: _____
Date: MM_____ / D D_____ / Y Y Y Y_____

Comprehensive Consent for Pediatric Dental Treatment & Behavior Management

This document authorizes examination, diagnosis, and dental treatment necessary to maintain or restore the oral health of my child. The dentist and staff will explain all recommended procedures in advance and welcome questions.

I authorize the dentist and staff of Monroe Pediatric Dental Care to perform dental procedures deemed necessary for my child's diagnosis and treatment, including but not limited to: Comprehensive and limited examinations, Dental cleanings, fluoride treatments, sealants, Dental radiographs (X-rays), Tooth-colored or silver fillings, Pulp therapy (pulpotomy, pulpectomy), Stainless-steel or tooth-colored crowns, Silver Diamine Fluoride (SDF), Space maintainers and other appliances, Local anesthesia, Nitrous oxide and Preventive and emergency dental care. INITIALS: ____

I understand that separate written consent will be required for extractions, oral surgery, sedation, protective stabilization, and hospital/operating room treatment. INITIALS: _____

I understand all dental procedures carry some degree of risk. Common risks include: mild discomfort; temporary or prolonged sensitivity; swelling or bruising; soft-tissue irritation (lips, cheeks, tongue); allergic reactions to materials, anesthetics or medications; rarely, numbness, tingling or altered sensation (which may persist); and systemic reactions (dizziness, nausea, vomiting, fainting). INITIALS: _____

I understand that teeth treated with pulp therapy may still develop pain, reinfection, internal or external resorption or abscess, and may require retreatment, extraction or space maintenance. Restorations (crowns/fillings) may fracture, leak, discolor or require repair/replacement over time. Tooth-colored resin fillings may be more prone to failure in children due to moisture control, clenching/grinding, poor oral hygiene or frequent sugary snacks/drinks; resin (white fillings)may discolor or fail earlier than other materials. INITIALS: ____

I understand that the dentist has explained the recommended treatment, as well as reasonable alternatives, including different materials or techniques, less invasive options, referral for specialist care, delaying treatment, or no treatment, and the possible risks and consequences of each option. I understand that no treatment or delayed treatment may increase the risk of pain, infection, swelling, fever, facial cellulitis, harm to developing permanent teeth, or the need for more extensive treatment in the future. The risks, benefits and alternatives have been explained in language I understand and I had the opportunity to ask questions. INITIALS: _____

(OVER —>)

I understand that dental treatment requires proper follow-up and good oral hygiene practices. Failure to attend recommended follow-up visits or maintain appropriate home care may lead to complications such as tooth shifting, impaction, orthodontic issues, or failure of restorations and appliances. My child must avoid sticky or chewy foods and must not use their teeth to bite or open objects, as this can damage or dislodge fillings, crowns, or appliances. I accept responsibility for helping my child follow these instructions and understand that the dentist cannot be held responsible for treatment failure resulting from poor home care, diet, or missed follow-up appointments. INITIALS: _____

I understand that my child's cooperation and behaviour will affect the quality and safety of dental treatment. To provide quality care, the dentist may use behaviour guidance techniques including (but not limited to) Tell–Show–Do (explaining and demonstrating before performing), positive reinforcement (praise or small rewards), distraction or modeling, and voice control (using a calm but firm tone) to redirect attention. If the child inadvertently moves or attempts to reach for a dental instrument or other equipment, a dental assistant may provide gentle physical support or restraint (such as holding the child's hands, stabilizing the head, etc) solely for the purpose of preventing injury or interruption of treatment. ***I understand that if my child is unable to safely tolerate dental treatment despite behavior guidance techniques, the dentist may discontinue treatment and recommend referral for sedation, general anesthesia or specialist care*****-additional costs may apply depending on referral location and insurance policies. Parents are encouraged to accompany their child during examinations and treatment visits; however, for some procedures the dentist may recommend the parent wait outside the operatory if this improves efficiency or cooperation. In the event an unforeseen condition arises during treatment, I authorize the dentist to perform any procedure deemed immediately necessary to preserve my child's health, comfort or safety.** INITIALS: _____

I authorize Monroe Pediatric Dental Care to use photographs, radiographs, and clinical records of my child for documentation, insurance processing, educational purposes or internal quality review, provided my child's identity remains confidential. I understand that communication regarding treatment or scheduling may occur through phone, text or e-mail. I confirm that I had the opportunity to ask questions and that all my questions have been answered to my satisfaction. INITIALS: _____

I understand that I am financially responsible for all services provided for my child. I acknowledge that any dental insurance coverage is an agreement between myself and my insurance company, and that I am responsible for any portion not covered or paid by insurance. I understand that dentistry, like all fields of healthcare, involves individual variability and that treatment outcomes cannot be guaranteed. I consent to the recommended dental treatment and authorize the dentist to perform any additional procedures deemed necessary for my child's comfort, safety, or oral health as part of their dental care. INITIALS: _____

Patient Name/DOB:_____

Legal Guardian Printed Name:_____

Guardian's Relationship to Patient: _____

Legal Guardian Signature_____**Date:** M M D D Y Y Y Y