## Patient Information

Child's Name:_____ Date:_____
Last First MI
☐ Male ☐ Female Child's Nickname_____
Social Security Number:_____
Birth date:_____ Age:_____ Hobbies/Interests: _____

Phone: (Home): _____ (Work): _____ Ext: _____
(Number for Appointment reminder): _____

## Health Information

*Please fill in your answers as thoroughly as possible. This will help in developing a complete dental health program for your child. Of course all information will be held in strictest confidence. By working together, we can find a way to achieve your goal of good dental health.*

Has your child ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies_____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Autism
- ☐ Behavioral Problems
- ☐ Birth Defects
- ☐ Bladder Condition
- ☐ Blood Disease
- ☐ Brain Injury
- ☐ Bruising Easily
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Child Abuse
- ☐ Cleft Lip or palate
- ☐ Diabetes
- ☐ Ear problems
- ☐ Epilepsy
- ☐ Eye problems
- ☐ Dizziness
- ☐ Fever Blisters
- ☐ Gagging
- ☐ Growth or
- ☐ Developmental Delay
- ☐ Headaches
- ☐ Hearing/Speech Problems
- ☐ Head Injury
- ☐ Heart Murmur/Defect
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Hyperactivity/ADD(H)
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous/Emotional Disorder
- ☐ Nutritional Deficiency
- ☐ Oral Ulcers
- ☐ Orthopedic Problems
- ☐ Pain in joints
- ☐ Premature birth
- ☐ Psychiatric care
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scoliosis
- ☐ Seizures
- ☐ Sickle Cell Disease
- ☐ Syndromes:_____
- ☐ Tumors
- ☐ Ulcers

- Was your child adopted? ☐ Yes ☐ No
- Was your child premature? ☐ Yes ☐ No How Many weeks? _____
- Did your child have a history of health problems at birth or during initial years? ☐ Yes ☐ No
  If yes, please list:_____
- Is your child presently taking any medication? ☐ Yes ☐ No
  If yes, please list: _____
- Does your child take any vitamins or supplements? ☐ Yes ☐ No
- Has your child had a history of taking medications frequently? ☐ Yes ☐ No
  If yes please list: _____
- Has any member of the family had a problem with general anesthesia ☐ Yes ☐ No
- Are immunizations, including tetanus, current? ☐ Yes ☐ No
- Has your child been admitted to a hospital or needed emergency care in the past two years? ☐ Yes ☐ No
- Is your child under the care of a physician? ☐ Yes ☐ No
  If yes, please explain;_____
  Name of physician: _____ Phone: _____
- Is there anything else you need to talk to the doctor about? ☐ Yes ☐ No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there are ever any changes to my child's health I will inform Dr. Shaw, at the next appointment, without fail. _____ *Initial*

## Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental office ☐ Yellow pages ☐ School ☐ Work ☐ Other_____
Name of person referring you to our practice: _____

## Dental History

It would be helpful if you would let us know what you are looking for in a pediatric dentist.

_____

Child first dental visit? ☐ Yes ☐ No

Date of last dental visit: _____ Reason for this visit: _____

Previous Dentist: _____ Any damage to your child's teeth or jaw? ☐ Yes ☐ No

If yes, what and when? _____

Has your child ever had an orthodontic exam or treatment? ☐ Yes ☐ No

History of ___Nursing Bottle Habits ___Thumb/Finger Sucking ___Pacifier ___Dental Grinding ___Sippy cup

Has your child experienced any unfavorable reaction from previous medical or dental care? ☐Yes ☐ No

If yes please explain: _____

How do you think your child will react to the dentist? _____

Has your child had recent dental pain? _____

How often does your child brush? _____ Is brushing supervised? ☐ Yes ☐ No

Is dental floss used? ☐ Yes ☐ No

Does your child receive: (check)

____Fluoride in vitamins ___Tap water ___Well water ____Fluoride tablets/drops ___Bottled water

## General Information

Father's Full Name_____ S.S.#_____Home Phone_____

Address_____ Birth Date_____

City_____State_____Zip_____ Employed by_____

Occupation_____ Bus. Phone_____

Mother's Full Name _____ S.S. # _____Home Phone_____

Address_____ Birthdate_____

City_____State_____Zip_____ Employed by_____

Occupation_____ Bus.Phone _____

Child lives with: ☐ Both parents ☐Mother ☐Father ☐ Other Name of family members who are patients here:

Responsible party: _____ _____

## For Patients covered by Dental Insurance

Insured name_____ Insured name _____

Group/Policy Number _____ Group/Policy Number_____

Employer name_____ Employer Name _____

Insurance Company _____ Insurance Company _____

I hereby authorize payment directly to Pamela R. Shaw, DDS, of the group insurance benefits payable to me, or if my insurance policy prohibits direct payment to the doctor, I hereby instruct the insurance company to make out the check to me and mail it in care of Pamela R. Shaw, DDS, 701 Metairie Road, Metairie. LA 70005. _____

Signature of insured person

### Consent for services

The undersigned hereby authorizes the taking of x-ray, study models, photographs or any other diagnostic aids deemed appropriate by Dr. Shaw to make a thorough diagnosis of your child's needs. I also authorize Dr. Shaw to perform all recommended treatment mutually agreed upon by me and use the appropriate medication and therapy for my child. I under-stand that dental care involves using anesthetic and involves a certain risk. Furthermore I authorize and consent that Dr. Pamela R. Shaw choose and employ such assistance as deemed fit to provide the recommended treatment.

Federal law requires that the patient of guardian who brings the child to the appointments is responsible for the fee incurred. I understand and agree that, regardless of my insurance benefits, I am ultimately responsible for the balance on my account for any services rendered. A service fee of 1 ½% per month (18%per annum) on the unpaid balance will be charged on all accounts exceeding 60 days. I understand that Dr. Shaw files insurance claims electronically. This is acceptable to me. I have received information about my privacy rights (HIPAA) and how my information can be used. I grant my permission to you or your assignee, to telephone me at home or at work, to discuss matters related to this form.

I have read the above conditions and agree to its contents

Signature: _____Date_____ Relationship to patient:_____

# Dr. Pamela R. Shaw, D.D.S

**Dentistry for Children · 701 Metairie Road · Metairie, La 70005 · (504) 838-8200**


## Information about the Pediatric Dental Appointment

In order to provide the best dental care of your child we would like to inform you more about the practice of dentistry for children and risks associated with this practice.

Patient Management

It is our intent that all professional care provided in our office shall be the best possible quality we can provide for each child. Providing high quality care in a safe manner can be difficult if the child lacks the ability to cooperate. All efforts will be made to obtain the cooperation of the children by the use of warmth, friendliness, kindness, and understanding. There are several behavior techniques that are used by the pediatric dentists to gain the cooperation of children to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. This includes:

1. **Tell-Show-Do:** The dentist or assistant explains to the child what is to be done, show an example on a tooth model or the child's finger and then the procedure is done to the child's tooth.
2. **Positive Reinforcement:** rewards the child who displays cooperative behavior with complements, praise, a pat on the shoulder, or a small prize.
3. **Voice Control:** The attention of the disruptive child is redirected by a change in the tone and volume of the dentist's voice.
4. **Mouth props:** A device is placed in the child's mouth to prevent closure of the child's teeth on dental equipment.
5. **Hand and/or head holding by dentist, dental assistant, or parent:** an adult keeps a child's body still so the child cannot grab the dentist's hand or sharp dental tools. This is to ensure patient safety.
6. **Medical Immobilization:** The child is placed in a restraining device made of cloth and Velcro. This is to ensure that the child does not hurt himself/herself by their movement.
7. **Nitrous Oxide Sedation:** nitrous oxide ("laughing gas") is a medication breathed through a nose mask to relax a nervous child. and enable him/her to better tolerate dental treatment. The child will remain awake but is expected to be relaxed and calm. The nitrous oxide is breathed out of the child's body within a few minutes of being turned off. We recommend an adult hold the child's hand as they leave the clinic.
8. **Oral Sedation:** Sedative drugs may be recommended to help your child receive quality dentistry in a safe manner if other behavior management techniques do not work. *Your child will not be orally sedated without you being further informed and obtaining your specific consent for this procedure. Your child's doctor will discuss the specific instructions and consents should your child need to be sedated for dental treatment.*
9. **General Anesthesia:** The dentist performs the dental treatment with the child anesthetized in the hospital operating room. *Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for this procedure. Your child's doctor will discuss the specific instructions and consents should your child need to be sedated for dental treatment.*

Pamela R. Shaw, DDS

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

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**For Office Use Only**

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Consent for Use and Disclosure of Health Information

**USE OF THIS FORM IS OPTIONAL**

**Purpose:** In cases where Pamela R. Shaw, DDS has directed not to rely on Acknowledgements as a basis to use or disclose health information, this form is used to obtain a patient's consent to our use and disclosure of the patient's protected health information to carry out treatment, payment activities, and healthcare operations, as described more fully in our Notice of Privacy Practices.

Pamela R. Shaw, DDS

## CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

**SECTION A: PATIENT GIVING CONSENT**

Name: _____

Address: _____

Telephone: _____ Social Security Number: _____

**SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY**

**Purpose of Consent.** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

**Notice of Privacy Practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Pamela R. Shaw, DDS Telephone: (504) 838-8200 Fax: (504) 838-8884

Address: 701 Metairie Road Metairie, LA 70005

**The Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**SIGNATURE**

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations. Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart. REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____