Patient Screening Form

ADA

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Health Information

Patient Name:_____ Name child goes by:_____
Birth Date:_____ Age:_____ Gender: M F

1. Has there been any change in your child's general health in the last year? ☐ Yes ☐ No
2. Has your child been hospitalized in the last two years? ☐ Yes ☐ No
3. Does your child have a heart condition or heart murmur? ☐ Yes ☐ No
4. Have you been told that your child should have antibiotics before dental visits? ☐ Yes ☐ No
5. Does either your family or your child have a history of complication from general anesthesia? ☐ Yes ☐ No
6. Has your child ever had radiation therapy? ☐ Yes ☐ No

7. Are your child's immunizations up to date? ☐ Yes ☐ No
8. If applicable, is the patient taking birth control medication? ☐ Yes ☐ No
9. Is the patient pregnant? ☐ Yes ☐ No

*If you answered yes to any of the questions above; please explain in detail:

_____

_____

_____

10. Date of last physical exam:_____ Name of Physician:_____ Phone:_____
11. List all of your child's **ALLERGIES**, include adverse reactions to any drugs, medication, latex, foods:

_____

_____

Has your child ever been diagnosed with any of the following? Please check those that apply:

- ☐ ADD/ADHD
- ☐ AIDS or HIV positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Behavioral problems
- ☐ Blood disease
- ☐ Bone/joint problems
- ☐ Cancer/Tumor
- ☐ Cerebral Palsy
- ☐ Chemical Dependency
- ☐ Cleft lip/palate
- ☐ Diabetes
- ☐ Developmental Delay
- ☐ Ear disorders
- ☐ Eating disorders
- ☐ Endocrine disorders
- ☐ Epilepsy/Seizures
- ☐ Eye disorders
- ☐ Excessive Bleeding
- ☐ Head Injuries
- ☐ Hemophilia
- ☐ Hepatitis (any type)
- ☐ High blood pressure
- ☐ Injuries to Face/Mouth
- ☐ Intellectually Disabled
- ☐ Jaundice/Liver disease
- ☐ Jaw joint pain
- ☐ Kidney Disease
- ☐ Lung Disease
- ☐ Organ Transplant
- ☐ Pacemaker
- ☐ Premature birth
- ☐ Psychiatric treatment
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell anemia
- ☐ Skin conditions
- ☐ Speech Delay/Therapy
- ☐ Stomach Problems
- ☐ Thyroid problems
- ☐ Tonsils/Adenoids surgery
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Upper respiratory infection
- ☐ Other_____

Please explain the condition further and/or list any other condition your child might have:_____

_____

List any **Medications** your child is currently taking: _____

Dental History information

Is this your child's first visit to the dentist? ☐ Yes ☐ No Previous Dentist:_____

Date of last visit:_____ Reason for visit?_____ Date of last x-rays:_____

To the best of my knowledge, the preceding answers and information provided are true and correct. If there is ever any change in my child's health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of Parent or Legal Guardian

_____ Date:_____
Doctor's Signature

Welcome to Honu Smiles Pediatric Dentistry!

Patient Information

Patient Name:_____ Nickname/Preferred Name:_____ Today's Date:_____
Last First MI

Birth Date:_____ Age:_____ ☐ Boy ☐ Girl

Names and ages of brothers and sisters _____

Responsible Party Information

Name:_____ ☐ Married ☐ Single ☐ Other

Birth Date: _____

Phone (Home):_____ (Work):_____ (Cell):_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Information:_____
Name Street City State Zip Code

E-mail address:_____

Name:_____ ☐ Married ☐ Single ☐ Other

Birth Date: _____

Phone (Home):_____ (Work):_____ (Cell):_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employer Information:_____
Name Street City State Zip Code

E-mail address:_____

Insurance Information

Primary

Insurance Plan Name and Address: _____

_____

Name of subscriber: _____
Last First MI

Subscriber's Birth Date:_____ ID #:_____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary

Insurance Plan Name and Address: _____

_____

Name of subscriber: _____
Last First MI

Subscriber's Birth Date:_____ ID #:_____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other_____

Name of person or office who referred you to our practice: _____

Consent for Treatment

As a minor child, it is necessary that signed permission be obtained from the parent or legal guardian before any dental treatment can begin. **It is also necessary for minor patients to be accompanied by an adult of legal age and who can give legal consent for treatment at each appointment.**

It is our intent that all care shall be of the best possible quality for each child. Providing high quality care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or dental instruments.

We make every effort to maintain the cooperation of young patients using warmth, humor, friendliness, persuasion, gentleness, love, and positive reinforcement. We find one-on-one communication to be most effective in gaining rapport and trust with your child. There are occasions where additional behavior management may be required to gain cooperation and prevent children from injuring themselves or dental staff. The following is a list of the behavior management techniques that are recommended by the American Academy of Pediatric Dentistry:

Tell-show-do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

Positive reinforcement: This technique rewards the child who displays any behavior that is desirable. Examples of rewards include compliments, encouragement, praises, or prizes.

Voice Control: The attention of a disruptive child is gained through lowering or raising the tone and volume of the dentist's voice. Care is taken not to make the child feel threatened. Content of the conversation is less important than the manner in which it is communicated.

Mouth Props a.k.a. "tooth pillow": A soft, rubber device used to assist the child in keeping their mouth open during a procedure and prevent their jaw from getting tired. This can also prevent accidental injury to the dentist's fingers.

Protective Stabilization - Only used if absolutely necessary. The dentist/assistant gently protects the child from movement by holding the child's hands, stabilizing the child's head or positioning the child safely in the dental chair, and/or utilizing stabilization

Nitrous Oxide Gas - These are specific techniques that will be used in this office with further discussion, explanation, separate verbal and written consent from a parent/guardian, and another dental appointment.

I hereby state that I have read and understand this consent, and that all questions about the procedure or procedures have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. I give my consent for the administration of local anesthetics and nitrous oxide (laughing gas). If my child ever has a change in his/her health or his medications change, I will inform the doctor at the next appointment without fail. At no time will care be rendered to a child without informing the parent or guardian of such care. For specific procedures, further information will always be provided. I further understand that this consent will remain in effect until such time that I choose to terminate it by written request.

_____ _____

Signature of Parent or Legal Guardian Date

Honu Smiles Pediatric Dentistry Office Policies

No-Show/Failed appointments:
We request that you give us at least a 24 hour notification if you are unable to keep an appointment. Not only is this a general courtesy, but this allows us to schedule other patients who may be waiting to be seen. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of $60.00 per child will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility. No future appointments can be scheduled without payment of this fee. If you have any questions regarding this policy, please let our staff know and we will be happy to address your concerns. We understand that circumstances may occur which may keep you from attending an appointment, however, **after the third failed appointment without proper notification, we will assist you in making arrangements to have your family's care** transferred to another dentist.

Late arrivals:
We value your time, therefore we make every effort to stay on schedule. Arriving late to your child's appointment does not allow time for the treatment planned for that appointment. If you arrive later than 10 minutes we may ask you to reschedule on a different date. Sometimes it is better to reschedule than to keep your family waiting. Calling to tell us that you will be late beyond 10 minutes will be considered a failed appointment.

Financial Responsibility:
Full Payment is expected at the time of service. Major credit cards, checks and cash are accepted. For patients with dental insurance, the co-insurance, deductible and non-covered expenses are due at the time of service. If you provide us with your insurance information and card, as a courtesy to our patients, we will complete insurance claim forms at our expense. The office will file to your insurance company the portion which should be covered by them. Billing by our office requires staff time and materials which result in higher fees. **To avoid any misunderstandings we ask that you take care of the financial portion at each appointment.**

Your signature below signifies that you have read and understand the policies explained in these paragraphs. By signing this form, you accept financial responsibility for this patient, authorize the release of any information necessary to process insurance claims and authorize insurance payments to Honu Smiles Pediatric Dentistry. You agree to inform the appropriate staff of Honu Smiles Pediatric Dentistry of any changes in the financial arrangements prior to treatment.

_____ _____

Child's Name Date of Birth

_____ _____ _____

Signature of Guarantor of Payment/Responsible Party Date Relationship to Patient

Confidentiality Policy

I have read and agree with the notice of Privacy Practices for Honu Smiles Pediatric Dentistry (HIPPA form).

I understand that my healthcare information is protected. I understand that, in order for a member of the Honu Smiles Pediatric Dental Team to leave detailed messages containing specific dental information on my voicemail or answering machine, I need to give permission for them to do so.

Consent for Shared Information with Family & Friends

Under the HIPPA Privacy Law Honu Smiles Pediatric Dentistry is permitted and we may make a professional judgment that certain disclosures are in your best interests even without this signature. I (the undersigned) understand that information is limited to verbal discussions and that no paper copies of my protected healthcare information will be provided without my signature on a Release of Information Form.

The name(s) listed below are family members or friends to whom I grant permission for Dr. John William Chang and his representatives at our clinic to verbally discuss my care using their best judgment and grant them permission to disclose dental information that is relevant to my child's care or relevant payment.

	Name	Relationship	Phone Number
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at anytime.

_____ _____ _____

Signature of Parent or Legal Guardian | Date | Relationship to Patient

Honu Smiles Pediatric Dentistry

Cell Phone & Video-taping Policy

Thank you for choosing our office for your child's dental needs. To respect the privacy of other families in the treatment area and waiting room, we restrict any use of phones, cameras, and video-taping of any form.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following office policy regarding use of cellphones, cameras, and video-taping.

_____ _____

Print Name Date

_____

Signature

Honu Smiles Policy Statement Regarding Vaccines

Due to the ongoing public health risk and in keeping with the positions of the American Academy of Pediatric Dentistry and the American Dental Association on vaccinations and preventing the spread of disease, we have decided to follow their lead and implement a policy to only accept patients who are in compliance with the Center for Disease Control (CDC) and the American Academy of Pediatrics guidelines regarding immunizations and vaccinations. If you would like to review these guidelines, please see www.cdc.gov/vaccines and www.aap.org.

If it is your choice to not follow these guidelines, we regrettably will not be able to treat your child. For a beneficial dentist-patient relationship to exist, there needs to be mutual trust and a shared treatment philosophy.

If your child is a current patient, we will provide emergency care, under certain conditions and for up to forty-five (45) days, to allow you time to find another provider.

Effective: February 1, 2019; revised March 6, 2019.

Initial _____