FLOURish
Pediatric Dentistry

2717 Commercial Center Blvd., Suite J220 Katy, TX 77494
Phone: 281-394-2520 FAX: 281-394-2580

New Patient Form

Today's Date:

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First Middle

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat: _____

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____

Child's Home #: (____)_____

SSN: _____

Child's Home Address: _____

_____
City State Zip

2 MOTHER'S INFORMATION

Name: _____

Mother Stepmother Guardian Birthdate: ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

3 FATHER'S INFORMATION

Name: _____

Father Stepfather Guardian Birthdate: ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

4 HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ YES ☐ NO

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____
City State Zip

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

Email Address: _____

7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

9 DENTAL HISTORY

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous dentist's name: _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain: _____

_____

_____

Why did you bring your child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting

Y N Nursing / Bottle Habits

Y N Nail Biting

Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain: _____

_____

Is the child's water fluoridated? YES NO

Is the child taking fluoride supplements? YES NO

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? YES NO

Does the child brush his/her teeth daily? YES NO

Floss his/her teeth daily? YES NO

10 HEALTH HISTORY

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD

Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Hemophilia/Blood Disorders
Y N Reflux/GI Problems

Please discuss any serious medical conditions the child has had:

_____

_____

Please list all the drugs the child is currently taking: _____

_____

Please list all drugs the child is allergic to: _____

_____

Child's Physician: _____

Phone #: (____) _____

Is the child currently under the care of a physician? YES NO

Please describe the child's current physical health:

GOOD FAIR POOR

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

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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 it is my responsibility to inform this office of any changes in my child's medical status.
I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

FOR OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT FORM FOR RECEIPT OF NOTICE OF PRIVACY PRACTICES CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date:_____ Patient Name:_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM RECEPTION AREA:

❑ First Name Only ❑ Proper Surname ❑ Other _____

PLEASE LIST ANY OTHER PARTIES WHO ARE ACTIVELY INVOLVED IN YOUR HEALTH CARE AND WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____

Name:_____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

❑ Cell Phone Confirmation
❑ Text Message to my Cell Phone
❑ Home Phone Confirmation
❑ Email Confirmation
❑ Work Phone Confirmation
❑ Any of the Above

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

❑ Phone Message
❑ Text Message
❑ Email
❑ **Any of the Above**
❑ **None of the Above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowl- edge and consent.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

Please ***print*** name of Patient
Legal Representative / Guardian

Please ***sign*** Patient / Guardian of Patient
Relationship of Legal Representative / Guardian

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

❑ It was emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because
❑ Other (please describe)

Signature of Privacy Officer_____

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BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental clinic be the best possible quality we can provide for each child.

Providing a high quality of care can sometimes be made very difficult, or even impossible, due to 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 open for long enough to perform the necessary dental treatment. Also, aggressive or physical resistance such as kicking, screaming, grabbing the dentists hands or sharp instruments can prevent the proper treatment being preformed.

All efforts will be used to obtain the cooperation of the adolescent patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding. There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of adolescent patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements.

The more frequently used pediatric dentistry behavior management techniques are as follows:

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

2. Positive reinforcement: This technique rewards the child who displays any behavior that is desirable. Rewards include compliments, praise, a pat on the back , a hug or a prize.

3. Voice control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of a command.

4. Mouth props: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.

5. Sedations: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or is unable to comprehend or cooperate for dental procedures. These drugs may be administered orally, by injection or as a gas (nitrous oxide and oxygen). The child does not become unconscious. You child will not be sedated without you being further informed and obtaining your specific consent for such a procedure.

6. General anesthesia: The dentist performs the dental treatment with the child anesthetized in a hospital operating room. Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for such a procedure.

Initials : _____ Date : _____

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FINANCIAL AGREEMENT

Child's Name: _____ DOB : _____

We appreciate you choosing our office for your child's dental care. At Flourish Pediatric Dentistry, we value our relationship with your family and would like to offer the following as our payment policy.

If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and copayments at the time of service.

You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.

Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of Flourish Pediatric Dentistry.

In case of insurance, we will be happy to help you receive the maximum benefits available under your policy.

As a courtesy, we will file your insurance benefits for you after every visit. However, please realize that the relationship is between you, the insured, and your insurance company.

If we do not receive payment from your insurance company within 60 days after submission of claim, you will be required to pay for all dental services in full.

Once the treatment plan and estimated insurance benefits are reviewed with you, we ask that you pay your out of pocket portion in full at the time of service.

If you are ever unable to keep a cleaning and check-up appointment, please call us at least 72 hours in advance to reschedule in order to avoid a $50 no show fee. If you are ever unable to keep a TREATMENT appointment, please call us at least 72 hours in advance to reschedule in order to avoid a $75 no show fee.

Please note that parents or guardians bringing the child into the office on the day of the service will be expected to pay for services rendered.

I have read and understand the payment policies for the office:

Date : _____

Parent/Guardian Name : _____ Signature of Parent/Guardian : _____

ANESTHESIA ALTERNATIVES, PLLC

CONSENT FOR ANESTHESIA

The following is provided to inform our patients of the choices and the risks involved with treatment under anesthesia. This information is not presented to make the patients more apprehensive but to enable them to be better informed concerning their treatment. The choices for anesthesia are basically three: local anesthesia alone, conscious sedation, or general anesthesia. These can be administered, depending upon the individual patient's medical requirements, either in an office or in a hospital setting.

The most frequent side effects of any intravenous anesthetic medications are drowsiness, nausea and vomiting (10-20%) and phlebitis. Most patients remain sleepy following their surgery for several hours which impairs coordination and judgment. It is recommended that adults refrain from driving and children remain in the presence of a responsible adult. Phlebitis is a raised, tender hardened, inflammatory response occurring in 2-4 % of patients that can have onset from 24 hours up to two weeks after the procedure. The inflammation usually resolves with local application of warm, moist heat, yet tenderness and a hard lump may be present up to a year.

I have been informed and understand that occasionally there are complications of the drugs and anesthesia, including but not limited to; pain; hematoma; numbness; infection; swelling; bleeding; discoloration; nausea; vomiting; allergic reaction; fluctuations in breathing pattern; heart rhythm, and/or blood pressure; brain damage and death. I further understand and accept the risk that complications may require hospitalization. I have been made aware that the risks associated with local anesthesia, conscious sedation, and general anesthesia vary. Of the three, local anesthesia is usually considered to have the least risks and general anesthesia the greatest risk. However, it must be noted that local anesthesia sometimes is not appropriate for every procedure.

I understand that anesthetics, medications, and drugs may be harmful to the unborn child and may cause birth defects or spontaneous abortion. Recognizing these risks, I accept full responsibility for informing the doctor of a suspected or confirmed pregnancy with the understanding that this will necessitate the postponement of the anesthesia. For the same reasons I understand that I must inform the doctor if I am a nursing mother.

I take full responsibility for informing the anesthesiologist of any prescription and over-the counter medications I have taken within the last 24 hours. Because medications, drugs, anesthetics, and prescriptions may cause drowsiness and incoordination which can be increased by the use of alcohol or other drugs, I have been advised to refrain from alcohol and street drugs, and not to operate any vehicle or hazardous device for at least twenty-four (24) hours or longer until recovered from the effects of the anesthetics, medications, and drugs that may have been given to me for my care. I also have been advised not to make any major decisions until after recovery from anesthesia.

I hereby authorize and request **Anesthesia Alternatives** and/or any other anesthesiologist to perform the anesthesia as previously explained to me, and any other procedure deemed necessary or advisable as a corollary to the planned anesthesia. I consent, authorize, and request the administration of such anesthetic or anesthetics (from local to general) by any route that is deemed suitable by the doctor in charge of the administration and maintenance of the anesthesia.

I have been fully advised of and completely understand the alternatives to sedation and general anesthesia and accept the possible risks and dangers. I acknowledge the receipt of and understand both preoperative and postoperative anesthesia instructions. It has been explained to me and I understand there is no warranty or guarantee as to any result and/or cure. I have the opportunity to ask questions about my anesthesia and am satisfied with the information provided to me.

PATIENT OR LEGAL GUARDIAN : _____ DATE : _____

WITNESS : _____

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INFORMED CONSENT FOR DENTAL TREATMENT

Child's Name :_____ DOB :_____

Your child is in need of some basic dental care. This form explains the care that your child needs, and requests your permission to provide that care. Specific Tooth Numbers are outlined on the Treatment Plan.

( ) Dental Fillings

Decay dissolves the tooth, and if not treated, will result in an abscessed tooth causing pain and infection. The dentist will remove the decayed part of the tooth and replace it with a silver alloy or tooth colored composite material to strengthen the tooth. A local anesthetic may be used that will "numb" the area being treated for one or two hours.

( ) Sealants

Back teeth have grooves and pits in which decay usually starts. The dentist or hygienist will "seal" the grooves with a plastic coating to help prevent the decay from starting. No anesthetic is needed and your child can eat right after.

( ) Stainless Steel Crowns and White Resin Crowns

If a tooth is badly destroyed by decay, a filling will not stay in place. Therefore, a tooth is trimmed around the sides and a preformed crown or "cap" is placed over the tooth to protect it from breaking. As with fillings, the area is usually treated with an anesthetic and the child will remain numb for one to two hours.

( ) Frenectomy

A Frenectomy is a minor surgical procedure to remove the band of tissue (frenum) that stretches between the inside of your upper lip to the area between your front teeth. A soft tissue laser is used for this procedure. Minor discomfort, swelling, bleeding and infection are risks of any surgery as well as the Frenectomy.

( ) Nerve or Pulp Treatment

When the decay or infection progresses far enough that the tissue inside the tooth is infected, all or part of that infected tissue must be removed and a special filling placed in order to keep the infection from spreading to other parts of the body. Pain or swelling after this work is rare and usually minor. Antibiotics may be used to control possible infections. After treatment, a crown or "cap" will be placed to help strengthen the tooth and keep it from breaking.

( ) Extraction or Removal of the Tooth

If the infection has spread too far to restore the tooth, it is often best to remove it to prevent infection from spreading. After "numbing" the area with anesthetics, the tooth is removed and the area packed with gauze to control bleeding. Care should be taken not to rinse for a couple of days or bleeding may begin again. Biting on gauze will usually stop the bleeding. Pain or swelling after this work is rare and usually minor.

( ) Routine use of Nitrous Oxide

Nitrous Oxide or Laughing Gas is used for procedures requiring local anesthesia. This is used to relax your child and is very safe. Nitrous Oxide never "chemically" combines with the body and only affects the patient while breathing it. It is **not** meant to put your child to sleep, only to **slightly relax** your child.

( ) Surgical Exposure/ Gingivectomy

Exposing an un-erupted tooth requires local anesthesia and is performed with a soft tissue laser, minimizing bleeding and discomfort. Minor discomfort is expected and swelling, bleeding and infection are possible risks as with any surgery.

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( ) Other Treatment: This treatment and possible complications have been explained to me by Dr. Kim or his associate

_____

_____

Common Risks
Common risks include but are not limited to:
1) Allergic reaction to latex gloves, local anesthetic or filling materials used.
2) Biting or excessive rubbing of the lips, cheeks, or tongue when numb which may lead to redness or bleeding.
3) Loss of a baby tooth that was near exfoliation.

Benefits and Alternative Treatments
Removing decay and restoring teeth, or removing teeth and placing space maintainers (where indicated) allows for more optimal oral health. This allows for better chewing, speech, and overall health. It also helps the permanent teeth erupt in a more favorable position .

Alternatives to treatment include
1) No Treatment, which will allow the decay to progress and may lead to infection.
2) Extracting the decayed tooth, even if it can be saved, 3) Not placing a space maintainer where required. This may lead to space loss and crowding. All alternatives require compromises that may affect your child's overall dental and medical health.

We expect your child will need approximately _____ appointment(s) to complete this work.

I understand my child _____ needs to receive the dental services explained to me and indicated above from Dr. Jaibum Kim or his associates.

I hereby state that I have read and understand this consent and that all questions about the procedures have been answered in a satisfactory manner. I also understand that I have a right to be provided with answers to questions which may arise during my child's treatment.

This signed Informed Consent Form is Valid for a period of <u>Six Months</u> from the dated Treatment Plan.

Signature of Parent/Guardian : _____ Relationship : _____

Witness : _____ Date : _____

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INSTRUCTIONS FOR PEDIATRIC PATIENTS PRIOR TO ANESTHESIA

The instructions herein must be strictly adhered to before commencing with anesthesia. Neglecting any of the following may compel the doctor to cancel the start of treatment.

Eating and Drinking : Patients for morning treatment shall have no food or liquid after midnight. Those for afternoon treatment may have non-fat solids six (6) hours before your scheduled appointment, and clear liquids up to three (3) hours preoperatively.

Medications : All medications should normally be taken at the regular time, including the morning of the procedure unless otherwise agreed upon by this office, and may be taken only with a sip of water before arriving.

Clothing and Makeup : Your child should wear comfortable, loose-fitting clothing (no tight jeans) with short sleeves to the appointment. Bring a change of clothing with you.

Change in Health : Any change in health, especially the development of a cold or fever, is very important. For your safety, you may be reappointed for another day. If possible, inform the office of any change in health prior to your appointment.

Arriving : Your child must be accompanied by at least one, preferably two responsible adults for the anesthetic appointment. Attend to bowel and urinary needs prior to the appointment. Plan to arrive a few minutes early so the doctor can review the medical history.

INSTRUCTIONS FOR PEDIATRIC PATIENTS FOLLOWING ANESTHESIA

Getting Home : Your child may be drowsy or dizzy for a time after discharge from the office. This is common as the drugs are wearing off. Your child may be irritable during this time. Children should be under adult supervision until the next day and not be allowed to travel unrestrained in a vehicle (use seatbelts or car seat), or play near streets, stairways or other areas where injuries could occur. Please call the Dental office upon arriving home as a follow up.

Pain : Depending upon the procedure performed, there may be some pain or discomfort. Allow the child to take the prescribed medication or Tylenol / Advil as directed to minimize or eliminate this problem. Children with fair skin my exhibit mild blotchiness during the immediate recovery period - this is not necessarily an allergic reaction. A low-grade fever is also possible due to dehydration. If this occurs, encourage fluids and analgesics. Feel free to call the Dental office at any time with any concerns.

Drinking and Eating : As soon as the patient is able, he or she should drink plenty of room temperature clear liquids such as water, fruit juices, Gator-aid, or carbonated beverages to help reduce the occasional nausea or vomiting in children following anesthesia and to prevent dehydration. Fluid during the day of surgery is important – solid food is not. Soft foods may be taken when desired, but not immediately forced.

Intravenous Site : An extremely small percentage of patients experience post-operative tenderness and/or redness in their hand or arm which is a chemical phlebitis associated with intravenous infusion. If this is occurs, patients should keep the arm elevated, apply warm (100 F) moist heat as much as possible, and take an anti-inflammatory agent. Should any other unusual situation or questions arise, contact the anesthesiologist or the dental office immediately.

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Conscious sedation is used to reduce or eliminate anxiety in dental patients so that safe, comfortable, quality dental treatment can be rendered. Your child will be mildly sedated, but will retain the ability to breathe naturally and respond to questions or verbal commands. During the dental procedure, your child's vital signs will be monitored continuously. The medication is prescribed in the smallest, safest, and most effective dose that will be administered orally ***one hour*** *prior to the dental visit.*

CONSENT FOR THE USE OF ORAL SEDATION
FOR PEDIATRIC DENTAL TREATMENT

This disclosure is not meant to alarm you, it is simply an effort to make you better informed so that you may give or withhold your consent to the dental procedure.

I, _____, as the legally responsible parent/guardian of _____, give my consent to the use of local anesthetics and sedative drugs as deemed appropriate by Dr. Jaibum Kim, in performing dental treatment as indicated on my child's examination chart and as previously explained to me.

I have been informed and understand that occasionally there are complications resulting from the sedative, including but not limited to, nausea; vomiting; allergic reactions; fluctuations in breathing pattern; heart rhythm, and/or blood pressure; brain damage and death.

Dr. Kim, or a member of his staff has discussed with me, to my satisfaction, these complications and the related risks. I understand and have been given a copy of the pre-operative instructions. The treatment and sedation procedures have been explained to me, to my satisfaction, along with possible alternative methods and their advantages and disadvantages.

I have read this consent and understand, to my satisfaction, the procedures to be performed and the risks involved.

Legally Responsible Parent/Guardian: _____

Witness : _____ Date: _____