Access Dental | Blue Hills DENTAL

PATIENT NAME________________________________

CHILD'S DENTAL & MEDICAL HISTORY

Welcome! So that we may provide you with the best possible care, please complete both sides of this dental & medical history form.

Has your child had the following disease or problems? **Active Tuberculosis** ☐ YES ☐ NO **Cough that produces blood** ☐ YES ☐ NO

IF YOU ANSWER YES TO EITHER OF THE QUESTIONS ABOVE, PLEASE STOP AND RETURN THIS FORM TO THE RECEPTIONIST.

Is this your child's first dental visit? ☐ YES ☐ NO

If NO, date of last dental visit__________ Last dental cleaning__________ Last full-mouth X-rays__________

Has your child had difficulty with previous dental visits? ☐ NO ☐ YES If yes, please describe__________

Has your child ever worn orthodontic appliances? ☐ NO ☐ YES If yes, please describe__________

How often does your child brush?__________ How often does your child floss?__________ Do you assist your child? ☐ YES ☐ NO

Is your child's water fluoridated? ☐ YES ☐ NO Does your child take fluoride supplements? ☐ YES ☐ NO

Are your child's teeth...?

	YES	NO		YES	NO		YES	NO
Sensitive to Hot or Cold?	☐	☐	Sensitive to Sweets?	☐	☐	Sensitive to Biting or Chewing?	☐	☐

Does your child engage in...?

	YES	NO		YES	NO
Thumb or finger sucking?	☐	☐	Chewing or biting fingernails?	☐	☐
Biting or sucking lips or cheeks?	☐	☐	Chewing hard objects (i.e., pencils)?	☐	☐
Grinding teeth?	☐	☐	Jaw clenching?	☐	☐
Mouth breathing?	☐	☐	Bottle nursing or pacifier habits?	☐	☐

Do your child's gums hurt or bleed? ☐ YES ☐ NO

Does your child have any pain or tenderness in the jaw joint, ear, or side of face? ☐ YES ☐ NO

Does your child have a health problem? ☐ YES ☐ NO

If yes, please describe__________

Is your child under the care of a physician? ☐ YES ☐ NO

If yes, please describe__________

Is your child taking any medications? ☐ YES ☐ NO

If yes, please describe__________

Has your child had any serious illnesses, hospitalizations or surgeries? ☐ YES ☐ NO

If yes, please describe__________

Has a doctor told that your child needs antibiotics or pre-medications before dental treatment? ☐ YES ☐ NO

Does your child have any allergies or adverse reactions to any medication or other substance(s)? ☐ YES ☐ NO

If yes, please describe__________

Are your child's immunizations current? ☐ YES ☐ NO

Indicate which of the following your child has had or has at present. Check "YES" or "NO" to each item.

	YES	NO		YES	NO		YES	NO
A.D.D./A.D.H.D.	☐	☐	Cold Sores/Fever Blisters	☐	☐	Lung Problem or Disease	☐	☐
A.I.D.S./H.I.V. Positive	☐	☐	Congenital Heart Disease	☐	☐	Measles/Mumps	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Mononucleosis	☐	☐
Asthma	☐	☐	Epilepsy or Seizures	☐	☐	Neurological Disorders	☐	☐
Asperger's or Autism	☐	☐	Hay Fever/Allergy/Hives	☐	☐	Psychiatric/Psychological Care	☐	☐
Blood Disease or Bleeding Disorder	☐	☐	Head Injury	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Blood Transfusion	☐	☐	Hearing Impairment	☐	☐	Sickle Cell Anemia	☐	☐
Brain Injury	☐	☐	Heart Condition	☐	☐	Stomach Problem	☐	☐
Cancer, Tumors, Growths	☐	☐	Heart Murmur	☐	☐	Tonsillitis	☐	☐
Cerebral Palsy	☐	☐	Hepatitis A B C (CIRCLE WHICH ONE)	☐	☐	Tuberculosis	☐	☐
Chemotherapy or Radiation Therapy	☐	☐	Kidney Infection or Disease	☐	☐	Other (Please list below)	☐	☐
Chicken Pox	☐	☐	Latex Allergy or Sensitivity	☐	☐	__________		

I understand that the above information is necessary to provide my child dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, Access Dental/Blue Hills Dental has my permission to ask my respective health care provider or agency to release such information to Access Dental/Blue Hills Dental. I will notify the dentist of any change in my child's health.

PARENT/GUARDIAN SIGNATURE __________ DATE __________ DENTIST REVIEW SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE ____/____/______

PARENT: Any changes to your child's health?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE ____/____/______

PARENT: Any changes to your child's health?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

HISTORY REVIEW DATE ____/____/______

PARENT: Any changes to your child's health?
☐ NO ☐ YES – If yes, describe changes below

DENTIST: Patient history reviewed.

SIGNATURE *(NON-EHR)* DATE

AUTHORIZATION FOR AGENT TO CONSENT TO DENTAL TREATMENT OF MINOR IN ABSENCE OF PARENT

I, _____, am the parent, legal guardian or authorized caregiver of _____.
FULL NAME OF PARENT FULL NAME OF CHILD PATIENT

I hereby, in my absence at Access Dental/Blue Hills Dental, give full authorization to _____ to:
FULL NAME OF AUTHORIZED AGENT

- ☐ provide transportation for my child to his/her dental appointment at Access Dental/Blue Hills Dental.
- ☐ sign any consent form that may be required by the Dentist and/or Access Dental that are necessary to render any and all necessary treatment for my child.
- ☐ consent to any X-ray, examination, anesthetic, dental diagnosis or treatment of my child deemed advisable by a dentist or hygienist and provided by that dentist or hygienist or under that dentist's or hygienist's supervision.

In the event of an emergency during the appointment, or while the child is on Access Dental/Blue Hills Dental property, said individual has the authority to make decisions on my behalf.

I assume full responsibility for any error(s) of commission or omission arising from the decisions made on my behalf by the aforementioned individual.

This authorization is made under California Family Code §6910.

PARENT/GUARDIAN SIGNATURE DATE

WITNESS SIGNATURE DATE

INFORMED CONSENT

PATIENT NAME_____ CHART NO.:_____

1. a. **ARBITRATION**

   Arbitration is the final process for the resolution of any dispute or controversy between a patient, or a personal representative of the patient, as the case may be, and Access Dental/Blue Hills Dental concerning the quality of patient services provided to a patient under this agreement for any dispute or controversy concerning the construction, interpretation, performance or breach of this agreement. By entering into this agreement, the patient agrees that such disputes shall be submitted to binding arbitration under the appropriate rules of the American Arbitration Association (AAA).

   I. Patient understands and agrees that any and all disputes between patient and Access Dental/Blue Hills Dental or its providers shall be resolved by submission to binding arbitration conducted by the AAA. Such Disputes or controversies include, but are not limited to, complaints concerning the quality, necessity or outcome of services provided pursuant to this Informed Consent Form, as well as the construction, interpretation, performance or breach of the terms of this Informed Consent Form.

   II. Patient further recognizes that by consenting to binding arbitration, patient is giving up the right to have such disputes decided in a court of law and/or before a jury. A declaration of a court or other tribunal of competent jurisdiction that any portion of this agreement to arbitrate is void or unenforceable shall not render any other provision hereof void or unenforceable.

   b. **INITIATION OF ARBITRATION**

   Arbitration can be initiated by filling a demand for arbitration with the AAA, located at 225 Bush Street, 18TH Floor, San Francisco, CA 94104-4207, telephone number (415) 981-3901. A demand form may be obtained from the AAA.

   c. **COSTS**

   In all arbitration matters submitted to the AAA, the party initiating demand for the arbitration shall advance all administrative fees connected therewith.

   d. **LOCATION**

   Arbitration proceedings shall occur in the county where the patient's treatment was performed, unless all parties to the arbitration otherwise agree in writing.

   e. **FORM OF DECISION**

   The parties agree that the arbitrators shall issue a written opinion. The award of the arbitrators shall be binding and may be enforced in any court having jurisdiction thereof by filing a petition of enforcement of said award. The arbitrator's award shall be accompanied by a written decision explaining the facts and reasons upon which the award is based, including the findings of fact and conclusions of law made and reached by the arbitrator.

2. **WORK TO BE DONE**: I understand that the following procedures may be performed on me as part of my dental treatments: X-rays, Fillings, Bridges, Crowns, Extractions, Impacted Teeth Removal, Root Canals, Dentures, Partial Dentures, Periodontal Treatments and possible other dental treatments.
3. **FILLINGS**: Fillings are procedures in which the dentist removes decayed tooth structure or a faulty restoration and replaces it with Composite Resin or Silver Amalgam fillings. I understand that these procedures could cause the teeth to be sensitive to hot and cold as well as chewing. The majority of the time, these sensitivities are temporary and they will go away within one (1) or two (2) weeks. However, there are times that due to the depth of the filling in the tooth, the pulp or the nerve of the tooth becomes irreversibly sensitive. In these cases, the tooth will need to be treated for root canal therapy and might possibly require a post and a crown to be fully restored. I understand that the dentist cannot guarantee that the teeth receiving fillings will not need to receive the above mentioned additional procedures and that I will be responsible for payments for any additional treatments needed to restore the teeth, if the initial filling procedure does not correct the problem.
4. **DRUG AND MEDICATIONS**: I understand that antibiotics, analgesics and other medication can cause allergic reactions causing redness and swelling of tissues, pain, vomiting and/or anaphylactic shock (severe allergic reaction).
5. **CHANGES IN TREATMENT PLAN**: I understand that during treatment it may be necessary to change procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the Dentist to make those changes as necessary.
6. **REMOVAL OF TEETH**: Alternatives to removal have been explained to me (root canal therapy, crowns and periodontal surgery, etc.) and I authorize the Dentist to remove the teeth outlined in the treatment plan and any others necessary under paragraph #5. I understand removing teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment.
7. **ANESTHESIA**: I realize the risks involved in receiving a local anesthetic, some of which are facial paralysis, inflamed tissue, adverse reactions to drugs causing cardiac arrest, miscarriage, hemorrhage, nerve damage and/or numbness. I also understand in rare instances patients may have allergic reactions to anesthetic, which may require emergency medical attention, or find that anesthesia reduces the ability to control swallowing, which increases the chance of swallowing foreign objects during treatment.
8. **CROWNS, BRIDGES AND CAPS**: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered, and that if I don't have the permanent crown(s) placed, permanent serious damage or loss of the

INFORMED CONSENT

tooth/teeth involved may ensue, and that if I delay placement I may cause the teeth involved to move making the permanent crown not fit properly. I also understand the lower edge of a crown is usually designed to rest near the gumline, which may increase the chance of gum irritation, infection or decay. Proper brushing and flossing at home, a healthy diet and regular professional cleanings are essential to help prevent these problems.

9. **DENTURES – COMPLETE OR PARTIAL:** I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me including looseness, soreness, and possible breakage, and relining due to tissue and bone change
10. **ENDODONTIC TREATMENT (ROOT CANAL):** I realize there is no guarantee that root canal treatment will save my tooth, and that complication can occur from treatment. Occasionally a root canal instrument will break off in a root canal that is twisted, curved or blocked with calcium deposits. Depending on its location, the fragment can be retrieved or it may be necessary to seal it in the root canal (these instruments are made of sterile, non-toxic surgical steel, so this causes no harm). It may also be necessary to perform an apicoectomy to seal the root canal. As a result of filing in the root canal, the incomplete formation of your tooth, or an abscess at the end of the tooth (called the apex), an opening may exist between the root canal and the bone or tissue surrounding the tooth. This opening can allow filling material to be forced out if the canal into the surrounding bone and tissue. An apicoectomy may be necessary for retrieving the filling material and sealing the root canal. Teeth that receive root canal treatment may be more prone to cracking and breaking over several years' time, which may ultimately require a bridge or partial denture.
11. **PERIODONTAL (TISSUE AND BONE) TREATMENT**: I understand that I have a serious condition, causing gum and bone inflammation or bone loss and that it can lead to the loss of my teeth. The alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions.

I hereby request and authorize the Dentists and their staff, to perform dental work upon me for the purpose of attempting to improve my appearance, function and the health of my mouth, teeth, bone and tissues, as explained above.

The effect and nature of the proceeding to be performed, and the risks involved, as well as the possible alternative methods of treatment have been fully explained to me.

I also authorize the operating Dentist and Assistants to perform any other procedure which they may deem necessary or desirable in attempting to improve the condition stated on the diagnostic treatment form, or treat unhealthy or unforeseen conditions that may be encountered during the operation.

I know that the practice of Dentistry and surgery is not an exact science and that therefore reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the treatment which I have herein requested and authorized.

Alternatives and possible bad reactions have been explained to me in detail. Complications, such as infection, hemorrhage and/or bleeding, scarring, contraction, possible deformities, prolonged healing time over the estimate, reaction to any drugs before, during and after surgery, numbness or itching of the tongue, lip, teeth, tissues, (Paresthesia), fractured jaw, Temporomandibular Joint (TMJ) Complication, which could cause localized and systemic pain requiring future treatments including joint surgery, etc., have been clearly explained to me.

CONSEQUENCES OF NOT PERFORMING TREATMENT: This course of treatment will help to relieve your symptoms. If no treatment were performed, you would continue to experience symptoms, which could include pain and/or infection, deterioration of the bone surrounding your teeth, changes to your bite, discomfort in your jaw joint and possibly the premature loss of these and other teeth.

Every reasonable effort will be made to ensure that your condition is treated properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed treatment, that you understand this information and that all of your questions have been answered fully.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT TO DENTAL TREATMENT AND THAT THE EXPLANATIONS THEREIN REFERRED TO WERE MADE. ANYTHING I DID NOT UNDERSTAND HAS BEEN EXPLAINED TO ME.

PATIENT/PARENT/RESPONSIBLE PARTY SIGNATURE DATE

WITNESS SIGNATURE DATE

DOCTOR SIGNATURE DATE