

## **A KidZ Dental Zone**

**J. Kyle House, DDS, DABPD  
419 State Ave., Suite 4  
Hood River, OR 97031  
(541) 387-8688**

**Thank you for choosing our practice for your child's dental care. We believe that you and your child deserve the very best care we can provide. It is our pledge to treat all of the patients entrusted to our care as if they were our own children.**

**So that we may best serve you please complete the enclosed forms before your appointment and bring them with you. The most important document in the packet is the medical history. Complete it as accurately as possible and feel free to make any comments on the form you think may be helpful in understanding your child's health status.**

**As a Pediatric practice we use a completely different vocabulary when explaining procedures to children and very anxious patients. For us to be most effective we ask that you briefly describe what a dentist does and what the child can expect; but please avoid using terms like: it won't hurt, shot, needle, pain or sharp. Avoid words and descriptions that are negative. We strive to accurately describe what a patient is going to experience using terms that are more descriptive of what will actually happen and express them on a level appropriate for the child's age.**

**Another big difference between our practice and other dentists is that we encourage the parent to accompany the child into the treatment area. There are some guidelines that we ask you to follow. Please refrain from speaking to the child when the dentist or nurse is talking. Children can only respond to one person at a time and an interruption may result in an important direction being missed. Please remain seated in the chair provided for you. If asked to leave please do so as quietly and quickly as possible. Feel free to ask any questions you may have. We want you, the parent, to be as informed as possible with regard to the treatment being provided to your child.**

**Very young children often cry even for simple examinations. This is normal behavior and in no way does it upset us, and you should not be embarrassed nor should you try to quiet the child. Crying actually facilitates our work since it is usually done with the mouth wide open.**

**Again, thank you for entrusting your child's care to us. If you have any questions please call.**

**Sincerely,**

**The Staff of A KidZ Dental Zone:  
Dr. J. Kyle House  
Dr. Steven Wohlford**

### **Financial Policy:**

**In an effort to keep dental costs down while maintaining a high level of professional care, our financial policy is payment at the time of services. As a courtesy to our patients, we provide a 5% discount when the bill is paid in full at the time of service. If you have dental insurance we will bill your insurance company for you. Patients with insurance will be required to pay, at the time of service, 30% of your total bill for preventive services and 50% of you total bill for operative procedures. Please note that under virtually all insurance plans this amount would be the patient's co-payment requirement. Our office reserves the right to charge \$25 for a failed confirmed appointment. We accept cash, checks, Visa and MasterCard. For your convenience, we do have applications for the CareCredit monthly payment plan. Please ask at the front desk for this information.**

PATIENT'S NAME \_\_\_\_\_  
 Last First Initial Nickname Date of Birth

PARENT'S/GUARDIAN'S NAME \_\_\_\_\_

DENTAL HISTORY - CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to a dentist? ..... YES NO
2. If not, how long since the last visit to the dentist? \_\_\_\_\_
3. Were any x-rays or radiographs taken when your child previously visited the dentist ..... YES NO
4. Does your child eat between meals? ..... YES NO
5. Does your child eat sweets, such as candy, soda pop, chewing gum? ..... YES NO
6. When does your child brush his/her teeth?  
 Upon arising  After eating any food  Right after meals  Before going to bed
7. How does your child receive Fluoride?  
 Community water level \_\_\_\_\_ ppm  Well water level \_\_\_\_\_ ppm  
 Fluoride drops or tablets  Fluoride rinse or gel
8. Have any cavities been noted in the past? ..... YES NO
9. Were any teeth (baby or permanent) removed by extraction? ..... YES NO
10. Have there been any injuries to teeth, such as falls, blows, chips, etc.? ..... YES NO  
 If so describe \_\_\_\_\_
11. Has your child had any problem with dental treatment in the past? ..... YES NO
12. Has anyone in the family, including parents, had orthodontics? ..... YES NO
13. Has your child ever received a local anesthetic? ..... YES NO
14. Has your child ever had occlusal sealants? ..... YES NO
15. Does your child think there is anything wrong with his/her teeth? ..... YES NO

MEDICAL HISTORY

1. Does your child have a health problem? ..... YES NO
2. Is your child under care of physician? ..... YES NO  
 If yes, since when and why? \_\_\_\_\_
3. Name of physician \_\_\_\_\_ Phone \_\_\_\_\_
4. Is your child receiving any medication? ..... YES NO  
 What? \_\_\_\_\_
5. Is your child allergic to penicillin, antibiotics or other drugs? ..... YES NO
6. Does your child have other allergies? ..... YES NO
7. Has your child had any serious illness? ..... YES NO  
 When \_\_\_\_\_ What \_\_\_\_\_
8. Has your child ever had surgery? ..... YES NO
9. Does your child have a heart murmur? ..... YES NO
10. Is surgery contemplated? ..... YES NO
11. Does your child experience severe or prolonged bleeding? ..... YES NO
12. Does your child have AIDS or has he/she tested HIV positive? ..... YES NO
13. Has your child tested positive for hepatitis? ..... YES NO
14. Is your child subject to nervous disorders? ..... YES NO  
 Fainting?  Seizures?  Dizziness?  Behavioral/Learning Problems?
15. Does your child have frequent headaches? ..... YES NO
16. Has your child had history of: (Circle appropriate responses.) diabetes, heart trouble, asthma, kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.

I have reviewed my above medical history. My general health status and medications are unchanged except as noted.

| Patient Signature | Reviewer | Date           |
|-------------------|----------|----------------|
| 1. _____          | _____    | ____/____/____ |
| 2. _____          | _____    | ____/____/____ |
| 3. _____          | _____    | ____/____/____ |
| 4. _____          | _____    | ____/____/____ |

MED ALERT

# CHILD DENTAL MEDICAL HISTORY

## PARENTAL INFORMATION

Mother/Guardian's Full Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Residential Address \_\_\_\_\_ City \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Zip \_\_\_\_\_ Drivers License \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ DOB \_\_\_\_\_

---

Father/Guardian's Full Name \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_  
Residential Address \_\_\_\_\_ City \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Zip \_\_\_\_\_ Drivers License \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_  
Work Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ DOB \_\_\_\_\_

---

## FINANCIAL AGREEMENTS

Payment is required for services rendered at the time of that treatment.

Method of Payment: \_\_\_\_\_ Cash \_\_\_\_\_ Check \_\_\_\_\_ Credit Card (MC or VISA) \_\_\_\_\_ CareCredit

Insurance Co: Name, Address, Phone No. \_\_\_\_\_  
Policy No. \_\_\_\_\_ Group No. \_\_\_\_\_ Employer \_\_\_\_\_  
Name of Subscriber \_\_\_\_\_ Soc. Sec. No. \_\_\_\_\_ DOB \_\_\_\_\_

*The policy of our office is that the parent who brings the child for treatment is responsible for all fees for treatment rendered.*

### Financial Agreement:

I understand that I am responsible for the payment of all fees for dental treatment for the patient named on the reverse side. I understand that I am responsible for any fee not paid by the patient's dental or medical insurance. The undersigned agrees: should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature

## PERMISSION FOR TREATMENT UPON A MINOR

I, being the parent or guardian of the named minor patient, do hereby authorize and request the performance of a dental examination (to include x-rays deemed necessary by the dentist to properly arrive at a diagnosis and treatment plan), teeth cleaning, flouride treatment and the application of pit and fissure sealants (plastic coatings) to the gooves of teeth for this patient. I understand I will be informed of all services before any services are rendered for my child. I understand I have the right to decline any of the recommended treatment once the treatment plan is explained to me. I understand that in refusing recommended treatment, A KidZ Dental Zone and staff are not liable for the consequences of refused treatment.

Signed \_\_\_\_\_ Date \_\_\_\_\_  
Child's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Witness \_\_\_\_\_

## Pediatric Behavior Management

Pediatric Dentists are specially trained in the care and behavior management of children. Part of their specialty training includes child and adolescent emotional and psychological development. We believe in approaching children in a gentle calming manner. The Doctor Patient relationship demands a certain level of cooperation from the patient. Appropriate cooperation enables us to provide quality care safely. A great deal of effort goes into successfully achieving this goal of safe, high quality care.

The dynamics of the dental office is complex and requires team work between the dentist, staff, child and parent. The team leader is by necessity the dentist, as he is responsible legally and morally for safety and quality. Every effort is made to make the experience as pleasant and comfortable for your child as possible. Most children will readily accept dental care as a natural and nonthreatening part of life. Some children are, by their nature, resistant, recalcitrant or otherwise uncooperative for even simple procedures and may require different approaches to behavior management. The initial purpose of a dental exam is to see how the child is going to react to the dentist and staff. The parent's responsibility is to grant permission for the dental staff to interact with the child and to not interrupt unless asked to become involved. This is a difficult step for many parents and requires a level of trust in the dentist and his staff. By intervening on the child's behalf the parent sends the message that dental care is not important and can be avoided if the child wants. Also, by becoming involved you prevent the dentist and staff from effectively evaluating the child's behavior and responses to determine the best course of action for that child.

There are certain rules of behavior that are essential in guaranteeing successful completion of dental care. Sometimes it becomes necessary for the dentist or a staff member to become verbally or physically authoritative to encourage an otherwise capable youngster into carrying out their part in the team dynamics. These moments will always be accompanied with positive reinforcement for any appropriate behavior and with words of comfort and reassurance.

There are several behavior management techniques that are recognized by pediatricians and pediatric dentists as appropriate for controlling dangerous or disruptive behavior in the clinical setting. Most children respond very well to these techniques. None of these behavior management techniques have resulted in long term "psychological trauma". Children have a basic need for adults to place certain restrictions on behavior. They have more difficulty handling too much freedom. Children feel more secure when adults demonstrate care and concern for them by placing and enforcing restrictions. Setting limitations teaches them the difference between appropriate and inappropriate behavior. We approach these management techniques in a matter-of-fact or natural manner. At no time do we present what we are doing as some sort of punishment, but rather we seek to help the child to cope with what may or may not be a stressful situation.

Some of the methods we employ to gain cooperation are:

- a. Tell-show-do.
- b. Positive reinforcement.
- c. Mouth props
- d. Voice control
- e. Passive and active physical restraints.
- f. Hand-over-mouth exercise.
- g. Conscious sedation.
- h. General anesthesia in hospital operating room.

Obviously, we attempt to find and use the least authoritative technique to fit the child and the situation. Sedatives and general anesthesia present risks to the child that other forms of management do not. These risks include excitation, nausea/vomiting, cessation of breathing, heart irregularities, brain damage and death. These risks are very, very slight, but they do exist. The risks of not treating dental disease actually carry a higher threat to the child. These risks include pain, swelling, fever, poor nutrition, poor academic performance, damage to permanent teeth, kidney and heart valve infections, sinus and brain infections, and death.

You are encouraged to discuss any aspects of these behavior management techniques with the dentist or staff.

I have read and understand the above information.

Printed name of parent/guardian: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_