Medical Health History

Patient Name: DOB: / / Date: / /

Responsible Party's Name: Patient's Sex: ☐ M ☐ F

1. Are you being treated by a physician at this time? ☐ Yes ☐ No

   Physician's Name: Physician's Phone Number:

   When was your last visit to this physician? Date: / /

2. Have you ever been a patient in a hospital? ☐ Yes ☐ No
3. Have you ever had any major illness or surgery? ☐ Yes ☐ No

   If so, please specify:

4. Do you have any allergies to any medication or substance (eg: medication, latex, foods, etc.)? ☐ Yes ☐ No

   If so, please specify:

5. Are you taking any medications or substances at this time? ☐ Yes ☐ No

   If so, please specify:

6. Do you have any problems with local anesthetics, antibiotics or any other types of medication? ☐ Yes ☐ No

   If so, please specify:

7. Are you pregnant or suspect that you might be pregnant? ☐ Yes ☐ No
8. Do you take birth control medication? ☐ Yes ☐ No
9. Do you smoke, chew, use snuff or any other forms of tobacco? ☐ Yes ☐ No

10. Have you ever had treatment or medical consultation for any of the following?

☐ Blood/Circulatory System	☐ Eyes	☐ Liver	☐ Nose
☐ Bones	☐ Gastrointestinal/Stomach	☐ Lungs	☐ Skin
☐ Ears	☐ Heart	☐ Muscles	☐ Throat
☐ Endocrine Glands	☐ Kidney/Bladder	☐ Nervous System	☐ Tonsils/Adenoids

☐ I have NOT had treatment for any of the above?

11. Have you ever been diagnosed with any of the following conditions?

☐ ADD/ADHD	☐ Brain Injury	☐ Heart Disease	☐ Pneumonia
☐ Allergy	☐ Cancer	☐ Leukemia	☐ Rheumatic Fever
☐ Anemia/Trait	☐ Cerebral Palsy	☐ Hemophilia	☐ Sickle Cell
☐ Arthritis	☐ Convulsions/Seizures	☐ Hepatitis	☐ Snoring
☐ Artificial Heart Valve	☐ Diabetes	☐ High Blood Pressure	☐ Speech Problems
☐ Artificial Joints/Prosthesis	☐ Emotional Disturbances	☐ HIV/AIDS	☐ Spina Bifida
☐ Asthma	☐ Epilepsy	☐ Latex Allergy	☐ Tuberculosis
☐ Autism	☐ Eye Problems	☐ Learning Disability	
☐ Behavioral Problems	☐ Fainting	☐ Heart Murmur or Condition	
☐ Bleeding Problems	☐ Hearing Loss	☐ Obstructive Sleep Apnea	

12. Is there anything else we should know about your health that we have not covered in this form? ☐ Yes ☐ No

    If so, please specify:

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my health.

Patient / Guardian Signature: Date: / /

Doctor's Signature: Date: / /

Health History Update: Are there any changes to your child's medical history?

☐ Yes ☐ No Patient / Guardian Signature: Date: / /

Health History Update: Are there any changes to your child's medical history?

☐ Yes ☐ No Patient / Guardian Signature: Date: / /

Molar Magic
General Dentistry and Orthodontic
for Kids and Young Adults

Commercial Insurance Information

Patient Name_____ **Patient Date of Birth**_____

Primary

Name of Insured: _____ Social Security # _____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
City State Phone #

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Plan Name and Address: _____

Secondary (if applicable)

Name of Insured: _____ Social Security # _____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
City State Phone #

Patient's relationship to insured: ☐Self ☐Spouse ☐Child ☐Other _____

Insurance Plan Name and Address: _____

Insurance Authorization

Please initial each item and sign below

_____ I understand that payment is due **before** the services are rendered

_____ I authorize release of information to all my insurance carriers

_____ **I understand that I am responsible for any part of my bill not covered by my insurance**

_____ I authorize payment directly to my doctor

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance

_____ I understand that if I receive payment from my insurance company for procedures completed in this office I am responsible for the entire remaining balance at the office.

_____ _____ _____
Signature of patient, parent, or guardian Date Relationship to patient

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Office Policy Regarding Patient Treatment

Our goal in treating your child is to provide the highest quality of care utilizing the most up-to-date techniques and materials in a safe, friendly environment by our experienced, caring and well trained staff. The following are our guidelines for treatment. If you have any questions or concerns regarding these guidelines, please feel free to ask one of our dentists or staff members anytime for clarification.

TREATMENT

We will treat your child the same way we would treat one of our own children. With very few exceptions, most children's dental treatment can be performed in the dental office with local anesthesia, nitrous oxide, and various patient guidance techniques (described on the back of this form). We feel these are safe and effective approaches to treatment for your child.

Many adults have a fear of dentistry and, as a result, they often postpone needed dental care until they have significant and complicated dental conditions. One of our goals is to demonstrate to children by example that regular dental visits to maintain dental health have a tremendous reward: a lifetime of healthy teeth and gums. Most of the treatment we perform on children (i.e., dental sealants and dental fillings) is designed to prevent future expensive and complicated dental procedures. We strive to educate children about dentistry and to establish a level of trust and confidence in those dental procedures aimed at preserving good oral hygiene. The result of our efforts helps to reduce the number of children who become adults fearful of dentistry. Winning the trust and confidence of our patients and parents is very important and requires special attention to detail.

It is our goal to ensure every child has a positive dental experience. We understand that every child is unique and handles new situations in different ways; however, securing a child's undivided attention is the first step toward that positive experience. Some children do not fear dental procedures and approach them with confidence. Others may feel uncertain and we, at Molar Magic, understand that the presence of a parent/guardian in the clinical environment can positively or negatively impact a child's ability to provide his/her undivided attention during treatment.

At Molar Magic, we welcome parents to accompany their children in the clinical environment. For some patients, the presence of a parent/ guardian helps rather than hinders the administration of dental procedures. For other patients, however, having a parent/guardian in the room where dental care is being administered may cause the patient to be inattentive or distracted, to lose their sense of confidence, to be more likely not to adhere to the directions the clinical team provides, and/or to be disinterested in establishing rapport with the dentist providing the care. These resulting behaviors not only interfere with the dental procedure, but they can also put the patient and the clinical staff at risk as well. The office manager along with the doctor and the parents/guardians will work together to identify the most beneficial solution. After all, we believe every child deserves to have positive dental experiences and working together with our parents/guardians helps to ensure that children recognize Molar Magic as a caring, safe, and friendly place.

Pediatric Dental Patient Guidance Techniques

We deliver professional care in our dental offices with the highest degree of quality for each child. Sometimes a child's apprehension or nervousness can interfere with the ability to address the child's dental needs. All efforts will be made to obtain the cooperation and trust of the child through the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

The following methods may be used to encourage your child to participate:

1. ***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 on a model or the child 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, which is desirable. Rewards include compliments, praise, a pat on the back, a hug, or a prize.

3. ***Voice Control:*** The attention of unfocused patients is gained by changing the tone of the dentist's voice. Content of the conversation is less important than the request; however, the content should always include only appropriate requests – ones that provide clear direction while also encouraging the child.

4. ***Mouth Props:*** A rubber or plastic aide is placed in the child's mouth to prevent closing when a child has trouble maintaining an open mouth.

5. ***Patient Immobilization by the Dentist:*** The dentist prevents the child from moving by gently holding the child's hands or upper body, stabilizing the child's head, or positioning the child to limit movement in the dental chair.

6. ***Patient Immobilization by the Assistant:*** The assistant prevents the child from moving by holding the child's hands, stabilizing the head, and/or stabilizing leg movements.

7. ***Medical Immobilization / Papoose Board:*** This is an immobilization aide for limiting the child's unanticipated movements to prevent injury and to enable the dentist to provide the necessary treatment. The child is comfortably placed in the pediatric immobilization aide and placed in a reclined dental chair.

8. ***Nitrous Oxide:*** Nitrous Oxide/Oxygen inhalation is a safe and effective technique to reduce anxiety, produce analgesia, and enhance communication between the dentist and the patient. This is commonly referred to as "laughing gas." The patient **does not** become unconscious.

Note: If you have questions regarding the methods listed above, please contact a front office or clinical staff member immediately. We want your child's dental experience to be a pleasant one while also ensuring we complete any or all of your child's required dental work with your child's safety and the safety of our clinical staff in mind.

I, (parent or guardian) of _____ acknowledge that I have read and understand the "Office Policy Regarding Patient Treatment" on the front side of this form and have reviewed the "Pediatric Dental Patient Guidance Techniques" above give consent for their use. All of my questions have been answered to my satisfaction.

_____ _____ _____

Signed Parent or Guardian **Relationship to Patient** **Date**

Molar Magic

General Dentistry and Orthodontic
for Kids and Young Adults

Family Information *(please print)*

Parent/Guardian Last Name | MI | Parent/Guardian First Name | Email Address

Cell Phone Number | Home Phone Number | Work Phone Number

Street Address | City | State | Zip

Name of Nearest Relative (not living with you) | Relative Phone # | # of Children in Family

Please list ALL children in your immediate family *(please print)*.

	Patient's Last Name	M.I.	Patient's First Name	Patient's DOB	Patient's Insurance and Insurance #
1.				/ /	
2.				/ /	
3.				/ /	
4.				/ /	
5.				/ /	
6.				/ /	
7.				/ /	
8.				/ /	
9.				/ /	
10.				/ /	
11.				/ /	