

BERT C. VASUT, DDS - PATIENT REGISTRATION

To help us meet all of your child's dental needs, please fill out these forms completely and accurately

PATIENT INFORMATION:

Name: _____ **Birth Date:** _____ **Age:** _____ Sex: F M
Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Do we see siblings? No () Yes () *If yes please list their names:* _____
Whom may we thank for referring you to our office? _____

PARENT/ GUARDIAN INFORMATION:

Father **Stepfather** **Guardian** **Marital Status:** _____
Name: _____ DOB: _____ SS# _____
Place of Employment: _____ Work # _____
Home telephone # _____ Cell # _____
Mailing Address (if different than above) _____

Mother **Stepmother** **Guardian** **Marital Status:** _____
Name: _____ DOB: _____ SS# _____
Place of Employment: _____ Work # _____
Home telephone # _____ Cell # _____
Mailing Address (if different than above) _____

Please provide us with your preferred email address as we will be confirming appointments via email and phone. Email: _____

INSURANCE:

*As a **courtesy** we will accept assignment of benefits from most insurance companies. In order to do so you must provide us with the following information:*

Do you have dental insurance? yes no
Would you like us to bill your insurance company? yes no
Name of person Insured: _____ Relationship to patient: _____
Insured's Social Security # _____ DOB: _____
Place of Employment: _____
Insurance Co.: _____ Telephone # _____ Group # _____
Claims Mailing Address: _____

DENTAL HISTORY:

Why is your child here today? _____

Is this your child's first visit to the dentist? yes no *If no, date of the last visit:* _____

Will your child be a cooperative patient? _____

Please describe how you think your child will behave today. Check all that apply:

friendly happy anxious timid afraid resistant

Does or did your child receive fluoride in any form? yes no *Please describe:* _____

Has your child inherited any dental characteristics? _____

Have there been any injuries to your child's teeth? _____

Place a check in the square below if your child has or has had any of the following problems:

<input type="checkbox"/> Cavities	<input type="checkbox"/> Toothache	<input type="checkbox"/> Bad Breath
<input type="checkbox"/> Crooked Teeth	<input type="checkbox"/> Sensitive to Sweets	<input type="checkbox"/> Bleeding Gums
<input type="checkbox"/> Sensitive to Hot/Cold	<input type="checkbox"/> Frequent Headaches	<input type="checkbox"/> Discolored Teeth
<input type="checkbox"/> Loose Teeth	<input type="checkbox"/> Teeth Bumped	

Does your child have any of the following oral habits?

Thumb Sucking Lip Biting Teeth Grinding
 Pacifier Use Other _____

How often does your child brush his/her teeth? _____

Does your child floss his/her teeth? yes no

At what age did your child stop using the: Bottle? _____ Sippy cup? _____

MEDICAL HISTORY:

Child's Physician _____
 Address _____ Phone # _____

Is your child in good general health? yes no

If no, please describe _____

Were there any problems at birth? yes no

If yes, please describe _____

Are your child's immunizations and booster shots up to date? yes no

Has your child ever been allergic to anything? yes no

What was the drug/ food and type of reaction? _____

Has your child had any surgical operations? yes no

If yes, for what? _____

Has your child ever been hospitalized? yes no

If yes, for what? _____

Has your child had or does he/she now have any of the following? CIRCLE YES OR NO:

- | | | | | | |
|--------------------------------------|--------|-----------------------------------|--------|--------------------------------------|--------|
| 1. Allergies/Sinus problems/drainage | Yes No | 12. Eating disorders | Yes No | 23. Steroid therapy or chemotherapy | Yes No |
| 2. Asthma | Yes No | 13. Abnormal bleeding or bruising | Yes No | 24. Nervous or mental disorders | Yes No |
| 3. Heart trouble or heart murmur | Yes No | 14. Blood transfusions | Yes No | 25. Convulsions or seizures | Yes No |
| 4. Rheumatic heart disease or fever | Yes No | 15. Birth defects | Yes No | 26. Frequent diarrhea or vomiting | Yes No |
| 5. Blood diseases or anemia | Yes No | 16. Kidney disease | Yes No | 27. Mumps, measles, or chickenpox | Yes No |
| 6. AIDS virus | Yes No | 17. Cleft lip or palate | Yes No | 28. Cancer, tumors, growths or cysts | Yes No |
| 7. Herpes virus or shingles | Yes No | 18. Scarlet fever or high fever | Yes No | 29. Tuberculosis or TB exposure | Yes No |
| 8. Diabetes | Yes No | 19. High or low blood pressure | Yes No | 30. Problems with Anesthesia | Yes No |
| 9. Ear, eye, nose or throat trouble | Yes No | 20. Liver disease | Yes No | 31. Thyroid disease | Yes No |
| 10. Stomach ulcers | Yes No | 21. Jaundice or hepatitis | Yes No | | |
| 11. Down's Syndrome | Yes No | 22. Autism/Asperger's/PDD/NOS | Yes No | | |

***If Yes, Please specify _____

CURRENT MEDICATIONS:

<u>Name / Strength (mg)</u>	<u>How often?</u>	<u>Reason taken</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

Do you consider your child to be? advanced in learning progressing normally a slow learner

Child's first language? _____ Second or other languages? _____

Is your child adopted? yes no If yes, at what age? _____

Child's favorites (pet, toy, color, hobby, etc.) _____

How does your child tolerate dental/medical care? _____

Authorization and Release:

I understand that payment of a calculated % is due at the time treatment is rendered, and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers' and/ or other health practitioners.

Signature of Parent/Guardian: _____

Printed Name: _____ Date: _____

**PEDIATRIC DENTISTRY CONSENT for DENTAL PROCEDURES
and ACKNOWLEDGEMENT of RECEIPT of INFORMATION**

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, extractions, etc. will be performed at a separate appointment after obtaining your permission.

State Law requires that we obtain your written informed consent for any treatment given your child as a legal minor.

Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it further.

1. I hereby authorize and direct Dr. Bert C. Vasut assisted by other dentists and/or dental auxiliaries of his or her choice, to perform upon my child the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2. In general terms the dental procedures or operation will include:

- A. Cleaning of the teeth and the application of topical fluoride.
- B. Application of plastic "sealants" to the grooves of the teeth.
- C. Treatment of diseased or injured teeth with dental restoration (filling or caps).
- D. Replacement of missing teeth with dental prosthesis.
- E. Removal (extraction) of teeth.
- F. Treatment of malposed (crooked) teeth and/or oral developmental or growth abnormalities.
- G. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1½ - 3 hours. Allergic reactions are rare. Your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child that they are going to get a "shot". We have our own special way of informing them of this.
- H. Use of behavior management techniques outlined on page 4.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize Dr. Bert C. Vasut to perform treatment as may be advisable to preserve the health and life of my child.

I hereby state that I have read and understand this consent and the behavior management techniques on page 4 and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Date: _____ Time: _____ am / pm

Patient's Name: _____

Signature of Parent or Guardian: _____

Relationship to Patient: _____ Witness: _____

BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental operatories shall 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, 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 the 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 the sharp dental instruments.

All efforts will be made to obtain the cooperation of the child dental 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 child 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 and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the 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 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 the 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. Physical restraint by the dentist: The dentist restrains the child from movements by holding the child's hands or upper body, stabilizing the child's head between the dentist's arm and body, or positioning the child firmly in the dental chair.
6. Physical restraint by the assistant: The assistant restrains the child from movement by holding the child's hands, stabilizing the head and/or controlling leg movements.
7. Sedation: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs are administered orally. The child remains conscious, but may become less active and more relaxed. Your child will not be sedated without you being further informed and obtaining your specific consent for such procedure.
8. General anesthesia: The dentist performs the dental treatment with the child asleep, under general anesthesia in the hospital operating room. Your child will not be given general anesthesia without your being further informed and obtaining your specific consent for such procedure.

Initial _____ Date _____

Bert C. Vasut, D.D.S.
2051 Cypress Creek Road
Suite N
Cedar Park, TX 78613
512-258-8888
drbertvasut@yahoo.com

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

Patient Name _____

Patient Address _____

Patient Phone Number _____

I authorize the professional office of my dentist named above to release health information identifying me under the following terms and conditions:

1. Information for treatment purposes.
2. To your insurance company (if applicable), pharmacist and to doctors to whom we refer.
3. To obtain payment from your insurance, to submit a prescription, and for sharing our diagnosis and information to doctors whom you are referred.

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization. If you sign this authorization, you can revoke it later. The only exception to your right to revoke is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient/Parent/Guardian Signature _____ Date _____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to Patient _____ Print Name _____