Sanders
Pediatric Dentistry
ERIC A. SANDERS, D.D.S.
BOARD CERTIFIED

As new patients we wish to welcome you to our practice. The confidence you have shown by selecting us to care for your child's dental needs is most gratifying. Please feel free to call us between regular check-ups with any questions or problems that may arise for your child.

The nature of children is such that dental emergencies do not always occur during regular office hours. Bearing this in mind, we can always be reached evenings and weekends by calling the office and then calling the number given on our recording. We will return your call as quickly as possible.

As a concerned Pediatric Dentist, I strive to keep up-to-date on the newest innovations in children's dentistry by attending post-graduate seminars and actively participating in the American Academy of Pediatric Dentist and numerous other pediatric dental societies.

But I am unable to spread the message of modern dentistry to everyone who needs to hear it. Studies show that 50% of all children 3 years of age have some decay. Even more startling is the statistic that 50% of all children 15 years of age have never been to a dentist! Since your child has benefited from preventive measures of modern dentistry in our office, we know you appreciate the importance of starting children early on the road to good dental health.

Please help in spreading the message to those who need to hear it. If you would like to make our office your office of referral, we will certainly accept the challenge. Our goal is to provide quality preventive dental care. We hope to make going to the dentist an enjoyable and educational experience so that your child will look forward to his or her 6-month check-up with enthusiasm.

Again, thank you for your confidence in our office.

Sincerely,

Eric A. Sanders, D.D.S. and Staff

2620 Country Club Road Lake Charles, LA 70605 • (337) 433-**KIDS** (5437) • www.SandersPD.com

Welcome

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WWW.SANDERSPD.COM

HEALTH HISTORY FORM

TODAY'S DATE: _____

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

TELL US ABOUT YOUR CHILD

Child's Name _____
Goes by: _____ ☐ Male ☐ Female
Siblings that we treat _____
Child's Birthdate _____ Child's Age _____
School _____ Grade _____
Child's Home # _____
SS# _____
Child's Home Address: _____
_____
Email _____

Who may we thank for referring you to our office? _____

MOTHER'S INFORMATION

Name _____
Mother Stepmother Guardian Birthdate _____
Employer _____
Work # _____ Ext. _____
Home # _____
Mobile # _____
SS # _____ DL # _____

FATHER'S INFORMATION

Name _____
Father Stepfather Guardian Birthdate _____
Employer _____
Work # _____ Ext. _____
Home # _____
Mobile # _____
SS # _____ DL # _____

Who is Accompanying the Child Today?

Name _____
Relationship _____
Do you have legal custody of this child? ☐ Yes ☐ No

PERSON RESPONSIBLE FOR ACCOUNT

Name _____
Relationship _____
Billing Address _____
_____
Home # _____
Work# _____
Mobile # _____
Email _____

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient_____
Policy Owner's Birthdate _____/ _____/ _____
Social Security # _____
Policy Owner's Employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____
Group # (Plan, Local, or Policy #) _____
Policy Owner's Name _____
Relationship to Patient_____
Policy Owner's Birthdate _____/ _____/ _____
Social Security # _____
Policy Owner's Employer _____

HEALTH HISTORY FORM

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 the child to the dentist today? _____
_____
_____

Does the child have any of the following habits?
Y N Lip Sucking / Biting Y N Nail Biting
Y N Nursing / Bottle Habits 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

HEALTH HISTORY

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding	Y N Disabilities/Special Needs
Y N Allergies to any Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorders
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV+/AIDS
Y N Congenital Birth Defects	Y N Kidney/Liver Conditions
Y N Convulsions/Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Allergies to Latex Product
Y N Tuberculosis	Y N Diabetes
Y N ADD/ADHD	Y N Autism

Please discuss any serious medical conditions the child has had
_____
_____
Please list all drugs the child is currently taking_____
_____
Please list all allergies_____
_____
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.

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 _____
_____
_____
_____

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GENERAL INFORMATION AND CONSENT

We are pleased to receive your child as a patient in our office and feel honored by the confidence you have placed with us. We sincerely desire to make his or her visits as pleasant as possible. We feel that we can better establish patient-doctor relationships if our parents and patients are familiar with the service and procedures of this office.

INITIAL VISIT: Each child receives a thorough examination on their first appointment. It usually includes a prophylaxis (cleaning of the teeth), topical fluoride, and dental x-rays, if they are needed. Oral hygiene instructions will be given to the patient and reviewed with the parent along with dietary recommendations. We employ all procedures available to reduce radiation risk including thyroid and gonadal lead apron, collimated x-ray machine. All x-rays are digital, providing fast results. We feel that it is extremely important for a child to have to have a full mouth x-ray (panorex), starting around the age of 5 or 6 to check for any problems such as extra permanent teeth, congenitally missing teeth, cysts or eruption problems.

PARENTS MAY ACCOMPANY THEIR CHILD: We have an open door policy in our practice. We want our parents to participate in their child's dental education and feel that it is important that they support our recommendation. We feel that we can prevent most of your child's dental problems with a team effort.

NITROUS OXIDE (LAUGHING GAS): Frequently, we will employ the "Happy Air Mask", nitrous oxide, to help reduce anxiety and fear of dental procedures. It is tremendously effective when treating children and is very safe.

PREMEDICATION: It is sometimes necessary to premedicate young children with sedatives in order to successfully perform certain dental procedures. If we recommend premedication, the medications and anticipated side effects will be carefully explained before the procedure. Children who are premedicated will have their vital signs monitored throughout the procedure.

HOSPITALIZATION: Some young or handicapped children requiring extensive treatment would benefit by having their work done under general anesthesia in a hospital setting. If we feel that this is a necessary way to treat your child, we will thoroughly discuss hospitalization with you.

PREVENTIVE DENTISTRY: Since some areas of Southwest Louisiana do not provide fluoride city water, preventive dentistry is extremely important. The American Academy of Pediatric Dentistry recommends that children who live in a non-fluoridated area routinely take fluoride supplements until the age of ten. Fluoride helps strengthen the teeth as they develop. Also, home fluoride rinse is recommended to strengthen the teeth that are presently in your child's mouth. We highly recommend sealants for the permanent molars and some secondary molars after they have fully erupted.

ORTHODONTICS: At each six month hygiene appointment your child will be checked for proper eruption of teeth and/or any malocclusion that may be developing. We will inform you of any treatment that we feel necessary for your child.

CHILDREN'S TIME: Although we schedule appointment times for the treatment of your child, our office operates on children's time. This means that occasionally some of our patients who are not particularly interested in getting their dental work done may take extra time so that they are more comfortable and less apprehensive. This will invariably play havoc with our schedule and cause some delays. So let me apologize now if we are running behind. We are guilty of letting our patients manipulate the schedule somewhat when we are trying to give them the best possible dental experience. We also see many emergencies since children may have accidents at home, school or play.

APPOINTMENT POLICY: As a growing pediatric dental practice, our schedule is sometimes booked several months in advance. While we understand some appointments can't be kept, we would like the courtesy of a phone call notifying us, so that we may give that appointment time to another child.

We intend to render dental services to your child as we would our own. If at any time you have questions concerning your child's dental health, please feel free to ask us.

PLEASE LET US KNOW IF YOU OBJECT TO THE USE OF FLUORIDE AND/OR X-RAYS.

AMERICAN ACADEMY OF PEDIATRIC DENTISTRY

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Please sign below to confirm you have read and received a copy of our office's General Information and Consent form.

Parent's signature _____Child's name _____

Reviewed by_____ Date_____
(Staff member)

Acknowledgement of receipt of notice of privacy practices

You may refuse to sign this acknowledgment

I, _____ have received a copy of this office's Notice of Privacy Practices on behalf of

Parent's name _____

Parent's signature _____

Date _____

Child's name _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communication barriers prohibited obtaining the acknowledgement

An emergency situation prevented from obtaining acknowledgement

Other (please specify) _____

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Cancellation Policy

Due to above average number of patients not showing up for scheduled appointments and a long waiting list, we are instituting a new cancellation policy as follows:

"Any patient that does not cancel a scheduled appointment at least 24 hours in advance and does not show up for the scheduled appointment, will be charged a cancellation fee of $25.00."

Your 24 hour cancellation notification will enable us to schedule patients that need to be seen right away and will shorten our waiting time for appointments.

Thank you for cooperating and understanding.

Eric A. Sanders D.D.S. and Staff

Parent's signature: _____
Date: _____

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Social Media Consent Form

I give my consent for Sanders Pediatric Dentistry to use pictures of my child on their social media tools which includes but is not limited to the Sanders Pediatric Dentistry Facebook page. I understand that these images will not be used for any other commercial use.

Please check on the boxes and sign below to give your consent.

I give consent. ☐

I do not give consent. ☐

Parent's Name: _____

Patient's Name:_____

Today's Date: _____

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