

THE RECTOR DENTAL GROUP
3905 N Wheeling Ave.
Muncie, IN 47304

THESE QUESTIONS ARE OF GREAT VALUE IN AIDING US TO BETTER UNDERSTAND YOUR CHILD.
 The information given will be used in strict confidence to prepare his/her dental chart.

Date: _____

Birth date: _____

Child's Name: _____ Nickname, if any: _____

Name and ages of any brothers or sisters: _____

Child's hobbies or interests: _____

Child's Physician or pediatrician: _____ Date of last visit: _____

Family Dentist: _____

Whom may we thank for referring you to us: _____

Purpose of today's visit (any specific concerns): _____

Do you have or have you had a history of any of the following?

Heart problems, murmur or surgery.....	Yes	No	Kidney problems.....	Yes	No
Rheumatic fever.....	Yes	No	Hepatitis or jaundice.....	Yes	No
Diabetes.....	Yes	No	Liver Problems.....	Yes	No
Cleft lip or Palate.....	Yes	No	Cerebral palsy or brain damage.....	Yes	No
Blood disorders (anemia, etc).....	Yes	No	Speech or hearing problems.....	Yes	No
Bleeding problem or hemophilia.....	Yes	No	Emotional or mental problems.....	Yes	No
Seizures or epilepsy.....	Yes	No	Learning or school related problems..	Yes	No
Asthma, tuberculosis or lung problems.....	Yes	No	Other (please explain).....	Yes	No

Circle One

Does your child have a health problem..... Yes No

Has your child had any unfavorable (allergic) reaction to drugs, including antibiotics, aspirin, or local anesthetic? If so please specify _____ Yes No

Is your child allergic to foods, pollen, etc? If so Please specify _____ Yes No

Is your child taking medicine? If so please specify _____ Yes No

Has your child ever been hospitalized? If so, Please explain _____ Yes No

Has your child ever had surgery? If so, Please explain _____ Yes No

Has your child had any history of thumb sucking, finger sucking, lip biting, or nail biting? If so, please underline the condition..... Yes No

Is your child adopted? (This question is asked so hereditary factors of dental and skeletal growth may be evaluated)..... Yes No

Has your child had any unfavorable experience in a dental or medical office..... Yes No

Do you consider your child to be high strung or generally nervous..... Yes No

Do you feel that your child will be an uncooperative dental patient..... Yes No

Has your child had any injuries to the teeth or mouth?.....Yes No
Has your child had any toothaches recently?.....Yes No
Is this your child's first visit to the dentist?.....Yes No
If no, date of last check up and where:_____

Father's Name:_____ Mother's Name:_____
Circle one: Single/Married/Divorced/Widowed

Your home address: Street _____ City _____
State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Email address: _____

Father's Occupation: _____

Name and address of business: _____ Phone # _____

Mother's Occupation: _____

Name and address of business: _____ Phone # _____

Relative's phone number and address: _____

Person responsible for child's account: _____

CONSENT

I certify the truth of all information given. I authorize the release of pertinent information to those persons requiring it for the treatment of my child, for the purpose of payment of the account, or credit references. Furthermore, since _____ is a minor, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any and/or all dental service can be started and accomplished by Dr. Rector and/or legally qualified associates. Such authorization is hereby granted to perform those diagnostic and treatment procedures, including local anesthesia or otherwise manage my child as may be deemed necessary or advisable.

Patient's Signature: _____ Date: _____

Witness: _____ Date: _____

THIRD PARTY PAYMENT INFORMATION

If your account is to be handled by any other method than direct payment to the office, please complete the following section for our records. Your help with this information aids in expediting your dental claim. Check one of the following:

Insurance _____ Medicaid _____

If Insurance:
Insurer's Name _____
Address _____
Social Security or Identification # _____
Insurance Company _____
Place of employment _____

THE RECTOR DENTAL GROUP
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT, PARENT OR LEGAL GUARDIAN GIVING CONSENT

Patients name: _____

Address: _____

Telephone: _____

Section B: TO THE PATIENT, PARENT OR LEGAL GUARDIAN-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of you, or your child's protected health information to carry our treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your, or your child's protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the change. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Dr. Rector
Telephone: 765-286-4017 Fax: 765-286-0372
Address: 3905 N Wheeling Ave., Muncie, IN 47304-1769

Rights to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not effect any action we took in reliance on this Consent before we received your revocation, and that we decline to treat you or to continue treating you if you revoke this Consent

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form I am giving my consent to your use and disclosure of my child's protected health information to carry our treatment, payment activities, and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, other than the parent, complete the following:

Personal Representative's name: _____

Relationship to Patient: _____

THE RECTOR DENTAL GROUP
AUTHORIZATION TO RELEASE DENTAL NEEDS

Our mission is to be dedicated to protecting the dental health of our patients. We treat healthy children as well as those with special needs and adults. We are proud to provide dental care to children and adults of the community. Our office combines the latest dental knowledge and technology together with care and compassion. We want every patient to have a positive dental experience. Our expert staff is great in creating this experience. Your commitment along with our excellent care, will allow for a lifetime of healthy teeth and gums.

Patients Name

Date of Birth

It is the policy of my office to not release dental patient information about your child, unless it is for patient care and treatment or payment. Our office is an open concept. We try to the best of our ability to keep the discussion of patient information to a minimum. If you wish for our dentist and/or office staff to leave messages for your child on your home telephone, message number, answering machine, work telephone, voice mail, cell phone, or pager, or to any other person, then you must complete the following:

I authorize The Rector Dental Group or staff to release dental patient information about my child by the following methods and agree it is my responsibility for notifying my dentist or office staff whenever I want this to change:

We can call your home or cell number if applicable and leave a message if no answer Yes ___ No ___

We can call you at work Yes ___ No ___

We can communicate with other professional offices and/or insurance companies
Concerning patient information Yes ___ No ___

Are you ok with our open concept practice Yes ___ No ___

Do you give permission to who may be accompanying the child the right to discuss any information pertaining to the above child (ie: billing, hygiene, treatment, and any other needs regarding the patient)

YES ___ NO ___

If no, the parent/guardian will need to bring child to every appointment and will be the only one that we will discuss information with.

Patient Signature/Legal Representative

Date

Witness

Date

SIGNATURE ON FILE

Patient's Name: _____
Last First Middle Initial

I hereby authorize payment of the dental benefits otherwise payable directly to The Rector Dental Group.

Signature (Insured Person) Date

The Rector Dental Group is authorized to provide pertinent information to those persons requiring it for the use of evaluating and administrating claims for benefits.

I authorize the use of this form on all of my insurance submissions.

I permit a copy of this authorization to be used in place of the original.

I understand that I am responsible for my bill.

Parent, Legal Guardian or Authorized Person's Signature Date

THE RECTOR DENTAL GROUP

PEDIATRIC DENTISTRY INFORMED CONSENT for PATIENT MANAGEMENT TECHNIQUES and ACKNOWLEDGEMENT of RECEIPT of INFORMATION

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

It is our intent that all professional care delivered in our dental operatories shall be of 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 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 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 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: Dr. Rector or assistant explains to the child what is to be done using simple terminology, 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 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, and prizes.
3. Voice control: The attention of a disruptive child is gained by changing the tone or increasing the volume of Dr. Rector'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: Dr. Rector restrains the child from movement by holding down the child's hands or upper body, or stabilizing the child's head between the dentist's arm and body.
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 the leg movements.

I hereby acknowledge that I have read and understand the consent, and that all questions about the behavior management techniques described have been answered in a satisfactory manner. I further understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment. I understand that this consent shall remain in effect until terminated by me.

Patients Name: _____ Date _____

Signature of Parent or Guardian: _____

Relationship to Patient: _____ Witness: _____

Signature of Doctor _____