Welcome!

from Dr. Bopp and Dr. Tarver

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 ABOUT YOUR CHILD

Name: ______________________________
LAST FIRST INITIAL

Nickname: ____________________ Age: ________

Birthdate: ____________________ ❑ Male ❑ Female
MONTH DAY YEAR

Names and ages of brothers and sisters: ____________________

____

Special interests, sports, or hobbies: ____________________

____

School: ____________________ Grade: ________

Child lives with: ❑ Mother ❑ Father ❑ Both ❑ Other

HOME PHONE: ______________________________

Mailing address: ______________________________

____
APT./CONDO # CITY STATE ZIP CODE

3 EMERGENCY CONTACT

IN THE EVENT OF AN EMERGENCY, WHO SHOULD WE CONTACT?

Name: ______________________________

Relationship: ____________ Phone: ____________

NEAREST FRIEND OR RELATIVE NOT LIVING WITH PATIENT:

Name: ____________ Phone: ____________

Address: ______________________________

AUTHORIZATION

I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim. I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

______________________________ ____________
SIGNED (PARENT/GUARDIAN) DATE

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

2 ABOUT YOU

FATHER'S NAME: ______________________________

Cell phone: ______________________________

Email: ______________________________

Employer: ______________________________

Social Security Number: ______________________________

Work phone: ____________________ Ext. ________

I would like to receive correspondence via:

❑ Phone ❑ Email ❑ Text Message ❑ All

MOTHER'S NAME: ______________________________

Cell phone: ______________________________

Email: ______________________________

Employer: ______________________________

Social Security Number: ______________________________

Work phone: ____________________ Ext. ________

I would like to receive correspondence via:

❑ Phone ❑ Email ❑ Text Message ❑ All

HOW DID YOU HEAR ABOUT OUR OFFICE? Check all that apply:

❑ Doctor (NAME) ______________________________

❑ Friend/Relative (NAME) ______________________________

❑ School (NAME) ______________________________

❑ Insurance Co. (NAME) ______________________________

❑ Phone Book ❑ Ledger ❑ Radio ❑ Magazine ❑ Office Pamphlet

❑ Other ______________________________

PLEASE TURN TO COMPLETE

4 PRIMARY INSURANCE

Dental Ins. Co.: ______

Insurance Co. phone #: ______

Group #: ______ ID#: ______

Employee name: ______

Marital status: ❑ Married ❑ Single ❑ Divorced

Relationship to child: ______

Employee: ______ ______
SOCIAL SECURITY NUMBER BIRTHDATE

Employer: ______

5 SECONDARY INSURANCE

Dental Ins. Co.: ______

Insurance Co. phone #: ______

Group #: ______ ID#: ______

Employee name: ______

Marital status: ❑ Married ❑ Single ❑ Divorced

Relationship to child: ______

Employee: ______ ______
SOCIAL SECURITY NUMBER BIRTHDATE

Employer: ______

6 DENTAL/MEDICAL HISTORY

Who is your family dentist? ______

Has your child been to the dentist before? ❑Yes ❑No

If yes, the approximate date of last visit: ______

Are there any dental problems that you are aware of at present? ❑Yes ❑No

If yes, please explain: ______

______

Does your child brush his/her teeth daily? ❑Yes ❑No

Is there a history of oral habits (thumb sucking, lip or nail biting)? ❑Yes ❑No

Please rate your child's oral health: ❑ Good ❑ Fair ❑ Poor

Is your child currently under the care of a physician? ❑Yes ❑No

Child's physician: ______

The approximate date of last visit: ______

Has your child ever had a serious illness or operation? ❑Yes ❑No

If yes, please explain: ______

Please rate your child's medical health: ❑ Good ❑ Fair ❑ Poor

Does your child have allergies or any unfavorable reaction to any medicine such as: Penicillin, Aspirin, Demerol, Local Anesthesia, Acetaminophen, Codeine, or Ibuprofen? ❑Yes ❑No

If yes, please list: ______

Is your child taking any prescription drugs? ❑Yes ❑No

If yes, please list: ______

What condition is this medication for: ______

7 HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS?

PLEASE CIRCLE

Y N Heart murmur
Y N Heart problems of any kind
Y N Convulsions/Epilepsy
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N HIV+/AIDS or blood borne disease
Y N Hemophilia
Y N Bleeding problems of any kind
Y N Hearing impairment
Y N Hyperactive
Y N Any operations
Y N Any stays in the hospital
Y N Seizures
Y N Fainting
Y N Cerebral Palsy
Y N Developmental delays
Y N Pneumonia
Y N Respiratory problems or Tuberculosis
Y N Bronchitis or Asthma
Y N Liver disease or Hepatitis
Y N Kidney or Bladder disease

Are there any other medical conditions or problems relating to your child? If yes, please list:

______

______

______

I understand that the information that 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 also authorize the dental staff to perform the necessary dental services my child may need.

The Parent or Guardian who accompanies the child is responsible for payment at time of services unless prior arrangements have been approved.

Signed
(Parent/Guardian): ______ Date: ______

Thank you for filling out this form completely. It will enable us to give your child the best dental care possible. If you or your child have any questions please feel free to ask us at any time.

REMEMBER ... HEALTHY TEETH ARE HAPPY TEETH!

DENTISTRY FOR CHILDREN

Harry E. Bopp, D.M.D. • Jordan Tarver, D.M.D.

1111 N. Parkway Frontage Rd. • Lakeland, FL 33803
Phone: **(863) 644-2408** Fax: **(863) 646-8493**
lakelandpediatricdentistry.com

I as parent of (________________________________) (____________________) give
First and last name of patient — Patient's date of birth

permission for, (________________________________) to accompany and give full consent to
First and last name of accompanying adult

Dr. Bopp, Dr. Tarver, Dr. Depew, Dr. Scheps and their office staff for the following dental procedures: examination, cleaning, fluoride application, required x-rays for proper diagnosis, necessary for treatment, conscious sedation, and nitrous oxide.

I consent and authorize Dr. Bopp, Dr. Tarver, Dr. Depew, Dr. Scheps and their staff to discuss personal medical/dental history about my child with the above authorized adult.

I request and authorize Dr. Bopp, Dr. Tarver, Dr. Depew, Dr. Scheps and their office staff to examine, clean, apply fluoride and provide my child with comprehensive dental treatment include but not limited to: silver/white fillings, crowns, extractions, impressions, space maintainers, pediatric bridge, sealants, conscious sedation, and nitrous oxide. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Bopp, Dr. Tarver, Dr. Depew, and Dr. Scheps to diagnose and/or treat my child's dental condition.

I understand that dental treatment may change. I authorize the above adult to consent to any treatment changes considered necessary by the dentists.

All of my questions have been answered to my complete satisfaction and I give full permission to Dr. Bopp, Dr. Tarver, Dr. Depew, Dr. Scheps and their office staff to treat my child. I understand that I will be responsible for any charges incurred on my child for dental treatment.

________________________________	____________________
Print name of Parent or Legal Guardian	Relationship to Child
________________________________	____________________
Signature	Today's Date

Please provide our office with a phone number in case we need to contact you on the day of your child's dental appointment.*

________________________________	____________________
Phone number you can be reached on day of appointment	Date of Appointment

Consent to Administer
Light Sedation and/or Nitrous Oxide for Dental Treatment

Some children cannot receive dental treatment in the usual manner due to their young age, anxiety, fear, previous dental experience, or nervousness. Options for these children include the following: 1) delaying treatment, 2) restraining the child to accomplish whatever urgent care is required, 3) sedating the child to a level at which dental care can be provided comfortably, 4) giving the child a general anesthetic in the hospital, or 5) proceeding with the treatment under less than optimal conditions. These possibilities all include various advantages, disadvantages, and risks. Delaying treatment may allow dental disease to progress to an emergency situation, including abscess formation, infection, pain, fever, and risk to the developing permanent teeth, or contribute to a long term dental problem. Upsetting or restraining a child may increase fear of dental treatment, and general anesthesia may adversely affect some children, not to mention the risk.

Factors considered when administering sedative drugs include medical history, previous reactions to drugs, age, weight, behavior of the child, and the treatment to be accomplished. Despite such considerations, the child's reaction to sedative drugs varies from little effect to profound sedation. Unfavorable reactions to sedative drugs include, but are not limited to nausea, vomiting, dizziness, breathing problems, allergic reactions, coma, and death. In addition to the sedative medication, nitrous oxide and oxygen may be used to supplement the sedation and deliver oxygen. Risks and complications with nitrous oxide are rare, and its effects are usually gone five (5) minutes after it is stopped. The most common complications are nausea and vomiting.

Proper and acceptable measures will be taken to optimize your child's safety and to achieve quality pediatric dentistry; however, you are given no guarantees or assurances of any sort as to the results that may be obtained. These measures may include a papoose board to prevent sudden movements or other measures which will provide your child a secure environment. Additionally, local anesthesia for pain control will be used. The risks involved for local anesthesia are as stated for sedative medications.

I certify that I have read and understand the above information and have had any and all questions concerning the procedures, dental materials being used, risks, and complications answered to my satisfaction. With the signing of this statement, I give Dr. Bopp, Dr. Tarver, Dr. Depew, and/or Dr. Scheps a knowing and voluntary informed consent to administer light sedation and/or nitrous oxide to my child.

______________________	______________________	______________________
Child's Name	Date of Birth	Date

______________________	______________________	______________________
Legal Guardian's Signature	Please Print Name	Relationship to Child

I AGREE TO NOT LEAVE THE OFFICE DURING MY CHILD'S TREATMENT. (______ INITIAL)

I AGREE TO HAVE TWO ADULTS (in the same vehicle) PRESENT ON THE DAY OF THE PROCEDURE. (______ INITIAL)

If needed, I give permission for my child to be secured with a papoose board for their safety.

______________________ LEGAL GUARDIAN'S SIGNATURE

______________________ PLEASE PRINT NAME

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_______________________ _______________________ _______________________

Child's Name | Date of Birth | Date

_______________________ _______________________ _______________________

Legal Guardian's Signature | Please Print Name | Relationship to Child

I AGREE TO NOT LEAVE THE OFFICE DURING MY CHILD'S TREATMENT.

(____)
INITIAL

If needed, I give permission for my child to be secured with a papoose board for their safety.

_______________________ _______________________

LEGAL GUARDIAN'S SIGNATURE | PLEASE PRINT NAME