Smile Academy, PC
Pediatric Dentistry
DR. DARIN L. KOTIL
402-964-9009

Patient ID # _____

Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____ Sex _____ Age _____

Nickname _____ SS#/SIN _____ Birthdate _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____ Phone _____

Responsible Party

Name _____ Relationship _____

Address _____ Email _____

City _____ State/Prov. _____ Zip/P.C. _____

Home Phone _____ Cell Phone _____ Work Phone _____

SS#/SIN _____ DL # _____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information ☐ Mother ☐ Stepmother ☐ Guardian

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ Father ☐ Stepfather ☐ Guardian

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Please see reverse side

Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # _____

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated?	☐ Yes	☐ No
Does your child take fluoride supplements?	☐ Yes	☐ No

Does your child:

Suck Thumb/Finger	☐ Yes	☐ No
Suck/Bite Lip	☐ Yes	☐ No
Bite/Chew Nails	☐ Yes	☐ No
Chew Hard Objects (pencils, etc.)	☐ Yes	☐ No
Grind Teeth	☐ Yes	☐ No
Clench Jaws	☐ Yes	☐ No

Date of Last Dental Visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits?	☐ Yes	☐ No
Has your child ever taken Fen-Phen/Redux?	☐ Yes	☐ No

Has your child ever had any of the following:

Asthma	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Tuberculosis	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No
Congenital Heart Defect	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No
Stomach, Liver or Kidney Problems	☐ Yes	☐ No
Convulsions/Epilepsy	☐ Yes	☐ No
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	☐ Yes	☐ No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses — When?

_____ _____

_____ _____

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

_____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

AUTHORIZATION & RELEASE

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 also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or Parent/Guardian if minor) Date

How Did You Hear About Us? *please circle one*

Website | Phonebook | Radio | Other:_____

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Smile Academy, PC
Pediatric Dentistry
DR. DARIN L. KOTIL
402-964-9009

Darin L. Kotil, DDS, PC - Consent for Treatment

TREATMENT

I hereby apply for acceptance of my child as a patient of Darin L. Kotil, DDS. I am aware that dental treatment will be rendered by Dr. Kotil, a licensed practitioner in the specialty of pediatric dentistry, as well as by his trained dental auxiliaries.

I consent to treatment for my child deemed necessary by Dr. Kotil and the standards set forth by the American Academy of Pediatric Dentistry (AAPD). The nature and purpose of the treatment will be explained to me to my satisfaction before treatment is rendered.

APPOINTMENTS

I agree to make my child available to dental treatment during regular office hours and to schedule appointments until necessary treatment is complete. Due to the number of children requiring treatment and the limited number of appointments that are available for treatment, I understand that a minimum of 24 hours notice is required to cancel my child's appointments. I understand that if I do not pay for dental services rendered or if I fail two appointments without prior notification, my child has the potential of being dismissed as a patient.

BEHAVIOR MANAGEMENT TECHNIQUES

I authorize Dr. Kotil to apply behavior management techniques recommended by AAPD that are appropriate to obtain cooperation is necessary when performing dental procedures to allow for the safest possible setting and treatment outcome. Following is a list and explanation of child psychology and behavior management techniques applied by Dr. Kotil and approved by AAPD in order to render treatment in the safest and most psychologically beneficial way:

- TELL-SHOW-DO- used to explain what is to be expected at each visit. We *tell* them what will be done, *show* them how it will be done, and *do* what we have explained to them. Praise is used to reinforce the child's cooperative behavior.
- VOICE CONTROL-used on a child who is capable of understanding, but is not listening to what is being said. Changing the tone or inflection of the voice can gain a disruptive child's attention. Keep in mind, this does not mean that anger is being presented to the child. Praise is used to reinforce the child's cooperative behavior.
- RESTRAINT-this technique will be explained to parents to their satisfaction before being applied. Restraint Is used to prevent injury to an uncooperative child during the necessary procedures.
- ACTIVE-the parent and/or assistant gently holds the child's head, arms, or legs to prevent harmful movement during treatment.
- PASSIVE-a Pedi-wrap is used primarily for very young children or emergency cases. It is used only when deemed absolutely necessary and only with the parent's consent.
- NITROUS OXIDE (commonly known as "laughing gas")-administered to an anxious child through a small- breathing mask placed over the child's nose. This allows them to better relax during the procedure while the child remains awake. When the mask is removed, the effects of the gas wear off in approximately 5 minutes.
- SEDATION/OPERATING ROOM-when unable to gain your child's cooperation with the following procedures, Dr. Kotil may recommend treatment under sedation or general anesthesia. This is a separate appointment and will be discussed in detail if and when it is recommended for your child.

I hereby state that I have read and understand the above information and give my written and implied consent for my child to be treated by Dr. Kotil and his dental team.

Parent/Guardian_____ Date_____

☐ On the date listed above, the office staff of Dr. Darin Kotil, DDS, PC, verified the responsible party's identity using photo ID & insurance card.