Oregon Kids
PEDIATRIC DENTISTRY

Patient Information

Child's Name: _____ **Preferred Name:** _____

Birth Date: _____ **Male:** ___ **Female:** ___ **Social Security #:** ____ - __ - ____

Home Address: _____

City, State, Zip: _____ **Phone Number:** _____

Who can we thank for referring you to us? (Please check all that apply.)

- ☐ Primary Care Doctor
- ☐ General Dentist
- ☐ Friend/Family
- ☐ School/Daycare

How have you heard about us? (Please check all that apply.)

- ☐ Social Media
- ☐ Google/Website
- ☐ Insurance Directory
- ☐ Walk in
- ☐ Billboard
- ☐ Newspaper or magazine
- ☐ Community Event
- ☐ Other: _____

Parent/Foster Parent/Legal Guardian Information

Name: _____ **Relationship:** _____

Birth Date: _____ **Email Address:** _____

Home Address (if different than child)**:** _____

City, State, Zip: _____ **Phone Number:** _____

Primary Dental Insurance:

Insurance Company: _____ **Subscriber's Name:** _____

Relationship to Patient: _____ **DOB:** _____ **SS#:** ____ - __ - ____

Employer: _____ **Subscriber's ID:** _____ **Group #:** _____

Secondary Dental Insurance:

Insurance Company: _____ **Subscriber's Name:** _____

Relationship to Patient: _____ **DOB:** _____ **SS#:** ____ - __ - ____

Employer: _____ **Subscriber's ID:** _____ **Group #:** _____

MEDICAL/DENTAL HISTORY

Patient Name: _____Male:___ Female:___ Date of Birth:_____

- ☐ Parent/Legal Guardian
- ☐ Documentation of Court Order on file
- ☐ Foster Parent:_____ Case Worker:_____ Phone Number:_____

Primary Care Physician Name: _____ Phone Number:_____

Specialists: Name of Facility/Doctor:_____Phone Number:_____

Name of Facility/Doctor:_____Phone Number:_____

Reason seen by Specialist:_____Date last seen:_____

Dental History

- ☐ Infant Frenectomy (Skip to Medical History section)

What concerns do you have about your child's dental care?

_____

How often does your child brush their teeth? _____

How often does your child floss? _____

Are you comfortable with the use of Fluoride for your child? ____ Yes ____ No

Is your child taking Fluoride supplements? ____ Yes ____ No ____ I'd like a prescription

How do you expect your child to do at today's visit? _____

Does your family have a history of dental anomalies? i.e. missing teeth, enamel disorder, etc.

_____

Has your child ever had a poor dental experience that you are concerned about?

_____

If this is your child's first visit with us, when were they last seen by a dentist? _____

Does your child have any oral habits? i.e. thumb sucking, pacifier, etc _____

Is there anything you would like us to be aware of before your child's visit today?

_____

How did you hear about our office? _____

Medical History

Allergies: __ No Known Allergies __ Medications __ Food __ Seasonal/Environmental __ Tape __ Latex

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Allergy: _____ Reaction: _____

Patient Medications: __ None __ Takes Medications (Please list below)

Medication: _____ Dose: _____ Frequency: _____ Reason: _____

Medication: _____ Dose: _____ Frequency: _____ Reason: _____

Medication: _____ Dose: _____ Frequency: _____ Reason: _____

Surgeries/Hospitalizations: __ N/A __ Admitted to the hospital or had surgery (Please list below)

Date: _____ Surgery/Hospitalization: _____ Outcome: _____

Date: _____ Surgery/Hospitalization: _____ Outcome: _____

Is your child on a special diet? ___ Yes ___ No

Is your child up to date on immunizations? ___ Yes ___ No

Allergic to any of the following? __ Aspirin __ Penicillin __ Codeine __ Acrylic __ Metal __ Latex __ Sulfa Drugs

__ Local Anesthetics

Does your child have, or have had, any of the following? Check all that apply

- ☐ AIDS/HIV Positive
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problems
- ☐ Bruises Easily
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Cystic Fibrosis
- ☐ Diabetes
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Fainting Spells/Dizziness
- ☐ Frequent Cough
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Heart Pacemaker
- ☐ Other Heart Issue
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Pain in Jaw Joints
- ☐ Premature Birth
  - ___ Weeks
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Rheumatism
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Yellow Jaundice

Has your child ever had any serious illness not listed above?

_____

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 the patient's health. It is my responsibility to inform my dental office of any changes in medical status.

Parent Signature: _____ Date: _____

Informed General Treatment Consent for Pediatric Dentistry

1. **Work to be done**

   I understand that I am having the following work done:

   ___ X-rays ___ Dental Examination ___ Dental Fillings ___ Zirconia Crown(s) ___ Stainless Steel Crown(s)
   ___ Pulpotomy/baby root canal therapy ___ Extraction(s) ___ Nitrous Oxide Sedation ___ Oral Sedation
   ___ General Anesthesia___ Ozone Therapy ___ Fluoride Treatment ___ Frenectomy ___ Space Maintainer

   _____ Initials

2. **Medications; Anesthesia**

   I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissue, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction) I understand that all medications have the potential for accompanying risks, side effects, and drug interactions. Therefore, it is critical that I tell my dentist of all medications my child is currently taking, which I have done

   _____ Initials

3. **Changes in Treatment Plan**

   I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to Dr. Lentfer to make any and all changes and additions as necessary

   _____ Initials

4. **Removal of Teeth**

   Alternatives to removal have been explained to me (root canal therapy, crowns, etc.) and I authorize Dr. Lentfer to remove the following teeth and any other necessary for reasons as described to me and explained in the extraction consent form. I understand that removing teeth does not always remove all of the infection. If present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in lips, teeth, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days, months, permanent) or fractured jaw. I understand my child may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility. **_____ Initials**

5. **Crowns**

   I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. Dr. Lentfer has discussed the crown options of Zirconia, Stainless Steel or Stainless Steel with white veneer coping. I understand that Zirconia crowns have a higher risk for fracture. I understand the veneer on stainless steel crowns with white coping may chip off and this does not indicate a need for replacement. If chipping of this coping occurs, it will be a cost that is my responsibility to replace the crown. **_____ Initials**

6. **Fillings**

Fillings are typically used to restore teeth damaged by decay when additional strengthening of the tooth is not required. Fillings can also be used to repair damaged or sensitive area of teeth near the gumline even if no decay is present. I understand that care must be exercised in chewing on fillings to avoid breakage. I understand that a more extensive restoration than originally planned may be required due to additional conditions discovered during preparation. I realize that fillings are rarely "permanent" and usually require periodic replacement. I understand that any time a tooth is prepared, for any reason, there is always irritation to the nerve of the tooth, which may result in post-operative sensitivity or, in some cases, permanent nerve damage requiring root canal treatment and a crown or removal of the tooth. It is difficult to predict how a tooth may respond to treatment. _____ **Initials**

7. **Pulpotomy/Pulpectomy (baby root canal)**

I realize there is no guarantee that root canal treatment will save my child's tooth, and that complications can occur from the treatment as described in the pulpotomy consent form. _____ **Initials**

8. **Ozone Therapy**

I understand that Ozone therapy is not recognized by the American Academy of Pediatric Dentistry or American Dental Association as a treatment of decay. I understand this is an alternative treatment with no guaranteed results. I understand the risks include inhalation of the gases which may cause a long-lasting coughing spell that may result in damage to the lungs. I understand Ozone therapy is recommended to arrest and/or prevent decay and is not a restoration. I understand ozone is not predictable and I have not been given any guarantees of success with its use. I acknowledge and understand additional restorative treatment is likely _____ **Initials**

9. **Fluoride Treatment**

Fluoride treatment is used to strengthen weakened enamel and is applied using varnish and is also present in some dental materials. I have been presented with options and given the choice to use or not use fluoride. I understand there is a risk of fluorosis that can be permanent damage to the permanent and primary teeth with the use of fluoride. _____ **Initials**

10. **Frenectomy**

A frenectomy is recommended when there is a need to gain and maintain good oral health, primarily to help breastfeeding, reduce maternal discomfort and prevent future problems associated with lingual and lip ties. No guarantees to the results have been given and I understand that not all consequences can be anticipated. I understand the recommended procedures, alternative options and anticipated results. _____ **Initials**

11. **Space Maintainer**

A space maintainer is used to hold space for permanent teeth. I understand that without the use of a space maintainer, permanent damage can occur and require orthodontic treatment in the future which would be an expense I would be responsible for. No guarantees have been made to me and I understand that the use of space maintainers can be unpredictable and results may vary. _____ **Initials**

I understand that dentistry is not an exact science and that no specific results can be assured or guaranteed. I acknowledge that no such guarantees have been made regarding the dental treatment I have authorized. I understand that the treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated fees are my financial responsibility. I have had the opportunity to read this form and ask questions; my questions have been answered to my satisfaction; and I consent to the proposed treatment.

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian printed name	Date

Office Policies

Welcome to Oregon Kids Pediatric Dentistry, the practice of Dr. Jordan Lentfer. We appreciate the trust you have shown us my by selecting our office to provide your child's dental care needs. We are committed to providing you with the highest quality oral health care in the most gentle, efficient, non-invasive and biologically compatible way possible. We look forward to helping your child. Below are our office policies. Please read these and feel free to ask any questions you may have. Please sign and date below to verify you have read, understand and accept these policies.

Parent/Guardian being present

It is imperative that a parent or legal guardian be present for an initial exam at our office. This is due to the need for legal consent forms to be signed that can only be signed by a legal guardian. After the first appointment, if we have written and signed consent from the parent or legal guardian, a friend or family member can bring your child to their appointments. If a parents or legal guardian is not present for the initial exam, we will have to cancel your appointment. Even with a signed power of attorney, there may be times we won't be able to provide treatment if another consent form or change of treatment plan is needed at which time we would need a legal guardian or parent to again consent for treatment.

Missed/Cancelled Appointments

When you make an appointment at Oregon Kids Pediatric Dentistry, we reserve that time exclusively for you and prepare a treatment room for your particular treatment. This policy makes it possible to give your child their reserved room immediately. We understand that life happens and sometimes you will have to cancel your child's appointment, but, in order to provide an opportunity for another child who needs our care to be seen, we request a 24 hour notice of cancellation. We do not charge for missed appointments, however, after three missed appointments with no notice or less than 24 hour notice, we will only see your child on an emergency walk-in basis or possibly dismiss your child from our practice.

Parents and siblings in Treatment Room

Dr. Lentfer and her team at Oregon Kids Pediatric Dentistry believe it is your right to be with your child for treatment whenever possible. Though most children do better for dental care when their parents are not present, some do better with, and it is almost always up to you if you choose to be present in the treatment room or not. That being said, there are some procedures that restrict parental access during treatment or limit access to only one parent/guardian allowed. They are:

1. **General Anesthesia** – when performing general anesthesia, a parent is never allowed in the treatment room. It is in your child's best interest, and for their safety, that the anesthesiologist and Dr. Lentfer have you wait in the reception area at the start of the procedure and during treatment. This is to allow the anesthesiologist and dentist the ability to give your child all of their care and attention. You will be with your child as soon as they wake up, if not before.
2. **Use of Solea Laser** – when using the Solea Laser for treatment, it is required that anyone present use protective eyewear. Due to this need and reducing risk of exposure to the laser that could damage the eyes, only one parent/guardian is allowed in the room during use of the laser. This is during most restorative procedures and surgical procedures, including frenectomies.
3. **X-Rays** – to minimize exposure to radiation, only your child is allowed in the treatment room while radiographs are being exposed. You will be allowed to watch from the doorway while your child has x-rays taken.

4. **Siblings** – we recommend siblings wait in the reception area whenever another sibling is having treatment done, be it a cleaning and exam or having fillings completed. This is so the child having treatment gets to have the full attention of their parents and the dental team. We understand it is not always possible to have another caregiver present, so we do make exceptions for cleanings and exams but siblings are not allowed at any time during appointments when your child is having fillings, extractions, use of laser, general anesthesia or any other form of restorative treatment. We do not allow young children to be left unattended in the reception area while you are with your child in the operative room, therefore it is important you arrange for care of other children ahead of time if you choose to be with your child during their treatment.

Medical History

We will have you update a medical history for your child annually, but please keep us updated with all changes in your child's medical condition(s). At times, Dr. Lentfer may need to consult with your child's other medical care providers regarding medicals and/or medical conditions.

Insurance Billing

As a courtesy to our patients, we will bill your insurance. You are responsible for all deductibles, co-payments and unpaid balances at the time of service and any balances due not covered y your insurance.

After Hours Emergency

Dr. Lentfer answers her own after hours calls whenever possible. At times, Dr. Lentfer does share on call with Dr. Stapleton, Dr. Drew and Dr. Ford. If your child has an after-hours emergency, do not hesitate to contact our office, we want to help you. If your child requires treatment after hours, there will be an additional after-hours emergency charge that varies depending on insurance coverage. Dr. Lentfer is unsure of costs that other dentists who cover on-call will charge you. In addition, Dr. Lentfer cannot guarantee that another on-call provider will accept your insurance.

Recommended Treatment

For your child's dentistry to have the greatest likelihood of success, it is necessary to follow through in a timely manner with Dr. Lentfer's recommendations for treatment. Failing to follow through with treatment could negatively affect the result of your child's dental treatment and be detrimental to their health. If you choose to not follow through with recommended care, we may have you sign a Refusal of Recommended Treatment form.

Release of Records

If you have been seen at another office, it is your responsibility to contact them and have them email, fax, or mail your child's records. If you choose to see another provider after seeing us, we will need you to sign a records release and it is your responsibility to give us proper information to forward your child's records. We do not charge for release of records. Please allow up to two weeks for us to forward your child's records.

By signing below, I acknowledge that I have read and understand the above information. In addition, I hereby authorize my child's physician(s) to release any pertinent facts regarding my child' medical conditions to Dr. Lentfer.

_____ _____ _____ _____ _____

Child's name | Parent/Guardian Signature | Printed Name | Relationship | Date

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. The privacy of your health information is important to us. Please review this information carefully.

Our legal duty: We are required by applicable federal and state law to maintain the privacy of your protected health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your protected health information.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and provide the new notice at our practice location, and we will distribute it upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Your Authorization: In addition to our use of your health information for the following purposes, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Uses and Disclosures of Health Information: We use and disclose health information about you without authorization for the following purposes.

Treatment: We may use or disclose your health information for your treatment. For example, we may disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You or Your Personal Representative: We must disclose your health information to you, as described in the patient rights section of this notice. We may disclose your health information to your personal representative, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the even

of your absence, or incapacity or in emergency circumstances, we will disclose health information based on a determination using our professional judgement disclosing only health information that is directly relevant tot the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization

Public Health and Public Benefit: we may use or disclose your health information to report abuse, neglect, or domestic violence; to report disease, industry, and vital statistics; to report certain information to the Food and Drug Administration (FDA); to alert someone who may be at risk of contracting or spreading a disease; for health oversight activities; for certain judicial and administrative proceedings; for certain law enforcement purpose; to avert a serious threat to health or safety; and to comply with workers' compensation or similar programs.

Decedents: We may disclose health information about a decedent as authorized or required by law

National Security: We may disclose to military authorities the health information of armed forces personnel under certain circumstances. We may disclose to authorized federal official's health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. We may charge you postage if you request paper copies mailed. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format if necessary. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associated disclosed your health information for purposes other than treatment, payment, healthcare operations, and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. In most cases we are not required to agree to these additional restrictions, but If we do, we will abide by our agreement (except in certain circumstances where disclosure is required or permitted, such as an emergency, for public health activities, or when disclosure is required by law). We must comply with a request to restrict the disclosure of protected health information of a health plan for purposes of carrying out payment or health care operations (as defined by HIPAA) if the protected health information pertains solely to a health care item or service for which we have been paid out of pocket in full.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. (You must make your request in writing.) Your

request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstance.

Electronic Notice: You may receive a paper copy of this notice upon request, even if you have agreed to receive this notice electronically on our website or by email.

Questions and Complaints: If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with the US Department of Heath and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the US Department of Health and Human Service.

Jordan Lentfer, DMD

Telephone: 54-636-4344

Fax: 541-636-4229

Email: Office@oregonkidspediatricdentistry.com

Address: 2921 Crescent Avenue, Suite 130, Eugene, OR 97408

Acknowledgement of Receipt of Notice of Privacy Practices

I, (print name) _____, have received a copy of the Notice of Privacy Practices.

Signature: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgment 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 us from obtaining acknowledgement

_____ Other (please specify)

_____

_____

Power of Attorney

I, _____ (legal guardian) give permission to those listed on the list below to bring _____ (patient) to dentist appointments at Oregon Kids Pediatric Dentistry. I give permission for the names on this list to make decisions on my behalf in regards to the patients dental care. I understand that some changes in treatment may require consent and signature from me, the legal guardian, and treatment may be rescheduled if I am not present at all appointments.

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Legal Guardian Printed Name: _____

Legal Guardian Signature: _____

Date: _____