THE DENTAL SPECIALISTS
PEDIATRIC DENTISTRY

Patient Bill of Rights:

At The Dental Specialists Pediatric Dentistry, we endorse a patient bill of rights. We strive to provide patients with personalized, comprehensive and patient-centered care. Thank you for trusting us with your oral health and welcome!

At The Dental Specialists Pediatric Dentistry, you have the right:

- To be treated with respect, consideration, and dignity by all doctors and team members in the dental practice.
- To privacy as it relates to your personal information and dental care. Patients shall be assured confidential handling of their dental and financial records and may approve or refuse their release, except when required by law.
- To the degree known, receive information regarding your dental diagnosis, treatment, prognosis, alternatives, associated risks, and the expected cost sufficient to assure an informed choice.
- To be given the opportunity to participate in decisions involving your dental care, except when such participation is not possible for medical reasons.
- To request an interpreter if necessary.
- To refuse participation in scientific research.
- To change dentists within the practice or transfer to another location.
- To be informed of the wide range of dental services available to you.
- To after-hours and emergency care should the need arise.
- To be informed of the payment/financial policy.
- To provide feedback, express grievances or make suggestions by verbally communicating them to a doctor or team member, through our patient satisfaction survey or by submitting them in writing to:

  The Dental Specialists Pediatric Dentistry
  2200 County Road C West, Suite 2210
  Roseville, MN 55113

Patient Rights and Responsibilities:

As a patient, you have the responsibility to:

- Be considerate of the privacy and rights of other patients and be respectful to all doctors and team members in the practice.
- Provide complete and accurate information, to the best of your ability, about your health, any medications, including over-the-counter products and dietary supplements, and any allergies or sensitivities.
- Follow the treatment plan prescribed by your provider for you and/or your children, and participate in your/their care.
- Accept personal financial responsibility for any charges not covered by your insurance.
- Notify The Dental Specialists Pediatric Dentistry, at least 24 hours in advance, if you are unable to keep a scheduled appointment(s).
- Understand and ask questions regarding your dental treatment.
- Continue care with recommended appointments and follow through with after care instructions.

If you have any questions, please speak with your doctor or call your dental practice. We are here for you.

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Patient Personal Information

Title _____ Nickname_____ Birth Date _____ Age _____
Last, First _____ Marital Status _____Gender _____
Address _____ Home # _____Work #_____
_____ Cell # _____Drive Lic_____
City, State, Zip _____ Student _____SSN _____
Email _____ School Name _____
_____ How did you hear about our practice? _____
Is patient responsible for paying bills? ☐ Yes ☐ No

Person responsible/guarantor for paying bills

Title _____ Nickname_____ Birth Date _____ Age _____
Last, First _____ Marital Status _____Gender _____
Address _____ Home # _____Work #_____
_____ Cell # _____Drive Lic_____
City, State, Zip _____ SSN _____
Email _____

Dental Insurance

Do you have **Primary** Dental Insurance? ☐ Yes ☐ No
Group No./Name_____
Insurance Name_____
Phone # _____
Employer Name_____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____
Birth Date _____
Subscriber ID _____

Do you have **Secondary** Dental Insurance? ☐ Yes ☐ No
Group No./Name_____
Insurance Name_____
Phone # _____
Employer Name_____
Subscriber Last, First _____
Subscriber Address _____
City, State, Zip _____
Relationship to Patient _____
Birth Date _____
Subscriber ID _____

Name: _____ DOB: _____

THE DENTAL SPECIALISTS

Medical Alerts

Do You Have the Following:

- ☐ Amoxicillin Allergy
- ☐ Aspirin or Ibuprofen Allergy
- ☐ Augmentin Allergy
- ☐ Epinephrine Sensitivity Allergy
- ☐ Erythromycin Allergy
- ☐ Clindamycin Allergy
- ☐ Codeine / Other Pain Killers Allergy
- ☐ Iodine Allergy
- ☐ Latex or Rubber Product Allergy
- ☐ Local Anesthetics Allergy
- ☐ Metals Allergy
- ☐ Penicillin Allergy
- ☐ Sedatives or Barbiturates Allergy
- ☐ Sulfa Drugs Allergy
- ☐ Other Allergy (list on Medical Questionnaire)

Are You Using the Following

- ☐ Antibiotics
- ☐ Anticoagulants/Blood Thinners
- ☐ Aspirin
- ☐ Cortisone/Prednisone
- ☐ High Blood Pressure Medication
- ☐ Insulin
- ☐ Motrin/Aleve/ Ibuprofen
- ☐ Oral Anti-Diabetic
- ☐ Nitroglycerin

Currently Taking or Ever Taken

- ☐ Actonel
- ☐ Aredia
- ☐ Boniva
- ☐ Fosamax
- ☐ Prolia
- ☐ Reclast
- ☐ Zometa
- ☐ Other Bisphosphonates

Check, if applicable

- ☐ Premedication Needed
- ☐ Alcohol/Drug Abuse
- ☐ Cancer/Tumor Growth
- ☐ Chemotherapy/Radiation
- ☐ Communication Issue
- ☐ Development Delay
- ☐ Learning Problems
- ☐ Organ Transplant
- ☐ Sensory Integration Disorder
- ☐ Wheel Chair

EYE, EAR, NOSE, THROAT PROBLEMS

- ☐ Canker Sores
- ☐ Cold Sores (Herpes)
- ☐ Ear Aches (Otitis)
- ☐ Frequently Dry Mouth/Sjogren
- ☐ Glaucoma
- ☐ Large Tonsils or Adenoids
- ☐ Hay Fever/Seasonal Allergies
- ☐ Hearing Impaired
- ☐ Sinus Trouble
- ☐ Vision Loss

HEART PROBLEMS

- ☐ Mitral Valve Prolapse
- ☐ Angina
- ☐ Chest Pain
- ☐ Congenital Heart Defects
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Heart Attack
- ☐ Heart Surgery
- ☐ Heart Damage
- ☐ Heart Murmur
- ☐ Heart Valve Replacement
- ☐ Irregular Heart Beat
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Rheumatic Fever

LUNG PROBLEMS

- ☐ Asthma
- ☐ Bronchitis
- ☐ Chronic Cough
- ☐ COPD
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Reactive Airway Disease
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Tuberculosis

VASCULAR/BLOOD PROBLEMS

- ☐ Anemia
- ☐ Leukemia
- ☐ Excessive, Prolonged Bleeding
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Leg Bypass Surgery

GASTROINTESTINAL PROBLEMS

- ☐ Acid Reflux
- ☐ Cirrhosis
- ☐ Colitis
- ☐ Crohn's Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hiatial Hernia
- ☐ Intestinal Bleeding
- ☐ Ulcers

GENITOURINARY PROBLEMS

- ☐ Dialysis
- ☐ Kidney Disease/Failure
- ☐ Urinary Tract Infections

MUSCLE/BONE/SKIN PROBLEMS

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ History of Skin Problems
- ☐ Joint Problems
- ☐ Muscle Problems
- ☐ Neck Problems
- ☐ Osteoporosis

NERVOUS SYSTEM PROBLEMS

- ☐ ADD/ADHD
- ☐ Alzheimer's Disease
- ☐ Anorexia / Bulimia
- ☐ Anxiety
- ☐ Autism Spectrum Disorder
- ☐ Bipolar Disease
- ☐ Cerebral Palsy
- ☐ Dementia
- ☐ Depression
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Injury to Head
- ☐ Migraines
- ☐ Muscular Dystrophy
- ☐ Numb Areas
- ☐ Paralysis
- ☐ Parkinsons Disease
- ☐ Seizures
- ☐ Stroke
- ☐ Other Psychiatric Condition

ENDOCRINE PROBLEMS

- ☐ Diabetes Type 1
- ☐ Diabetes Type 2
- ☐ Low Blood Sugar
- ☐ Thyroid Problems

IMMUNE SYSTEM PROBLEMS

- ☐ AIDS/HIV
- ☐ Lupus
- ☐ Rheumatoid Arthritis

OTHER PROBLEMS

- ☐ Jaundice
- ☐ Liver Disease
- ☐ Measles, Mumps, Chickenpox
- ☐ Other Medical Condition

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Pediatric Dental Questionnaire

Does your child have a toothache or other immediate dental problems? ☐ Yes ☐ No

If yes, please describe. _____

Is this your child's first dental visit? ☐ Yes ☐ No

If **NO**, please list the name of the Dentist, date and reason seen. _____

Has your child ever had an unfavorable dental experience? ☐ Yes ☐ No

If yes, please describe. _____

How often does your child brush his/her teeth? _____

How often are child's teeth flossed? _____

Does your child use fluoride toothpaste? ☐ Yes ☐ No

Has your child ever had a fluoride treatment? ☐ Yes ☐ No

At what age did your child stop using the bottle? _____

At what age did your child stop using the sippy cup? _____

Social History

Child's first language? _____

Is your child adopted? ☐ Yes ☐ No

If yes, at what age? _____

Does the patient have any siblings? ☐ Yes ☐ No

If yes, please list names and indicate if we see siblings? _____

Please rate how your child tolerates dental care ☐ very well ☐ ok ☐ very poorly

Please rate your anxiety at this moment ☐ low ☐ moderate ☐ high

Do you consider your child to be: (please select one of the following)

☐ Advanced in learning ☐ Progressing normally ☐ A slow learner

Does your child have any of the following oral habits? (Check all the apply)

☐ Thumb or Finger Sucking ☐ Lip Biting ☐ Teeth Grinding

☐ Pacifier Use ☐ Mouth Breathing

Does your child now have, or ever had any of the following problems?

☐ Cavities ☐ Toothache ☐ Bad Breath

☐ Crooked Teeth ☐ Sensitivity to Sweets ☐ Bleeding Gums

☐ Sensitivity to Hot or Cold ☐ Frequent Headaches ☐ Discolored Teeth

☐ Loose Teeth ☐ Teeth Bumped

Drinking Water Source at Your Home:

City Water Supply (Name of City) _____

Private well or source other than city? ☐ Yes ☐ No

If yes, has a fluoride analysis been done? ☐ Yes ☐ No

If so, date of analysis of fluoride content? _____

For Admin Use Only		
Date		Name

Additional Comments:

Parent/Guardian Information					
	Mother		Stepmother		Guardian
	Name		DOB		
	Place of Employment				
	Father		Stepfather		Guardian
	Name		DOB		
	Place of Employment				

For Admin Use Only		
Date		Name

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Patient Medication Form

Patient Name		ID #		DOB		Gender	__ M __ F

Medication & Dosage	Indication for Use	Start Date

Updated Form – Admin Only	
Date	**Name**

For Admin Use Only – Entered into QDW		
Date		Name

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New Patient Radiograph Request Form

(Send this form to your current/former dentist)

Please send my/our most current Complete Series & Bitewing Radiographs to:

(Please print the practice information for The Dental Specialists Pediatric Dentistry location you wish to have your records sent to below.)

Practice: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Email: _____

Please print name(s) for ALL patients whose records need to be ent:	Please print corresponding date(s) of birth:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Patient/Parent Signature: _____ Date: _____