Justin A. Shuffer, D.D.S.
Specialist in Pediatric Dentistry
www.drjustinshuffer.com
(909) 599-0283

Welcome to our practice! We pledge to render the finest pediatric dental care possible for your family.
Thank you in advance for the valuable information requested below. Today's date_____

Child (Patient) Information

Child's Name _____ Nickname _____ Gender M F
Age _____ Date of Birth _____ Child's Pediatrician _____
Pediatrician's Address _____
_____

Whom may we thank for referring you to our office? _____
Is your child covered by a dental plan or insurance? Yes No If yes, which insurance? _____

Is this your child's first dental visit? Yes No
If no, name of previous dentist _____ Approximate date of last visit _____
Reason for this dental visit _____
Is your child currently in pain or requiring treatment Yes No

Do you know any other children that are patients in this office? Yes No
If yes, please list their names _____

Has your child had any bad dental experiences? Yes No
If yes, please explain _____
_____
_____

What are your child's favorite things? _____

Was your child bottle fed? Yes No If yes, until what age? _____
Was your child breast fed? Yes No If yes, until what age? _____
Does your child drink juice? Yes No If yes, how many ounces/day _____
Does your child drink soda? Yes No If yes, how many cans/week _____
Does your child brush and floss alone? Yes No
Does your child drink tap water? Yes No
Does your child drink milk or juice in bed? Yes No
Is there a water filtration system in the home? Yes No

Does your child have any of the following mouth habits?
Thumb sucking Finger sucking Lip sucking Tooth grinding
Mouth breather Tongue thrusting Foreign objects in mouth

Has your child had any injuries to his teeth, mouth, head, or jaw? _____
Does your child receive fluoride in any of the following forms?
Vitamins Water supply Tablets/drops
Toothpaste Rinse/gel Prescription dosage _____ mg/day

Please circle any items your child routinely eats/drinks between meals:
Juice Gummy vitamins Fruit snacks Chocolate milk
Soda Crackers/chips Sports drinks Candy

Health Patients Name: _____

Is your child in good health? Yes No
Are your child's immunizations up to date? Yes No
Does your child have any conditions requiring treatment currently? Yes No
If yes, please explain _____

Does your child currently take any medications? Yes No
If yes, please list _____
Does your child have any allergies or reactions to any medications? Yes No
If yes, please list _____
Has your child ever been hospitalized or had surgery? Yes No
If yes, please explain _____
Has your child had any history of:

Heart Trouble	Yes	No	Diabetes	Yes	No
Heart Murmur	Yes	No	Fainting/Seizures/Epilepsy	Yes	No
Rheumatic Fever	Yes	No	Growth/Develop Problems	Yes	No
Acid Reflux	Yes	No	Hearing/Speech Problems	Yes	No
Anemia	Yes	No	HIV/AIDS	Yes	No
ADD/ADHD	Yes	No	Hemophilia	Yes	No
Asthma	Yes	No	Hepatitis/Liver Disease	Yes	No
Autism	Yes	No	Kidney Disease	Yes	No
Birth Defects	Yes	No	Leukemia	Yes	No
Blood Disorders	Yes	No	Mental/Emotional Issues	Yes	No
Blood Transfusions	Yes	No	Premature Birth	Yes	No
Bone or joint problems	Yes	No	Spina Bifida	Yes	No
Brain Injury	Yes	No	Syndrome	Yes	No
Cancer or Growths	Yes	No	Tuberculosis	Yes	No
Cerebral Palsy	Yes	No	Eye Problems	Yes	No
Child Abuse	Yes	No	Other _____		
Chronic ear infections	Yes	No			
Cleft Lip/Palate	Yes	No			

Dentist Signature: _____ Date: _____

Parent/Guardian Information

Father Full Name:	Mother Full Name:
Driver's License No.:	Driver's License No:
Social Security Number :	Social Security Number:
Birthdate:	Birthdate :
Address:	Address:
City:	City:
State: Zip code:	State: Zip Code:
Home Phone:	Home Phone:
Business Phone :	Business Phone:
Cell Phone:	Cell Phone:
Email:	Email:
Employer:	Employer:
Occupation:	Occupation:

Child lives with: Both Parents Mother Father Other

I give this Dental office my authorization to contact me on the above cell phone regarding, dental appointments, account balances, insurance information, etc.
If I do not give authorization check here: NO _____ and please give an alternative way for us to contact you:
_____

Signature _____ Relationship to patient _____ Date _____

For PatientsCovered by Insurance

Primary Carrier
Subscriber Name:
Subscriber ID:
Insurance Company, Address, and Phone

Employer Name, Address, and Phone

Group/Policy Number

How long have you had this coverage?

Secondary Carrier
Subscriber Name:
Subscriber ID:
Insurance Company, Address, and Phone

Employer Name, Address, and Phone

Group/Policy Number

How long have you had this coverage?

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file. I have reviewed the following treatment plan. I authorize the release of any information relating to this claim. I authorize payment of the dental benefits directly to the dentist.

_____
Signature of patient or parent (if minor)

_____
Signature of patient or parent (if minor)

Assignment of Benefits (If insured)
I hereby assign all dental benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s) to issue payment check(s) directly to **Justin A. Shuffer, DDS – Pediatric Dentistry** for dental services rendered to myself and/or my dependent(s) regardless of my insurance benefits, if any. The office of Justin A. Shuffer, DDS will provide an **estimate** of insurance coverage upon request. I understand that the office of Justin A. Shuffer, DDS is not responsible for inaccurate estimates. Payment(s) of a dental claim is not guaranteed by any insurance and is based on eligibility and policy coverage at the time a claim is submitted. **I understand that I am responsible for any amount not covered by insurance and I agree to pay any balance amount, in a timely manner.** Initial: _____

Office Policy
Your appointment time is important to you, your doctor, and to others who are in need of pediatric specialty dental care. We charge for missed appointments and our requested cancellation policy is a 24 hour notice for all types of visits. A $35 Fee will be assessed per child for any missed or cancelled appointment without appropriate notice. Your cancellation must be made during regular office hours. You will be personally responsible for this charge. This charge will not be billed to, nor paid for, by your insurance company. As always, emergencies and unforeseen circumstances are taken into consideration. Initial: _____

Informed Consent Information
Name: _____

Required Treatment: I understand that my child requires the following treatment:
□ Radiographs/X-rays □ Local Anesthetic Injection □ Filling/Restoration □ Prophylaxis □ Extraction □ Sealants □ Pulp Treatment □ Crowns □ Space Maintainer □ Mouth Prop

Radiographs/X-rays – A radiographic image is formed by a controlled burst of X-ray radiation which penetrates oral structures at different levels allowing pictures of the teeth, bones, and surrounding soft tissues to screen for and help identify problems with the teeth, mouth, and jaw. X-ray pictures can show cavities, cancerous or benign masses, and hidden dental structures (such as wisdom teeth).
_____
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Local Anesthetic Injection: Injection of local anesthesia is needed to eliminate or minimize the potential discomfort associated with dental treatment. Local anesthetic injections may cause prolonged numbness of the face, cheek, lips, chin, tongue, and taste buds of the tongue. These areas can also experience altered feelings such as itching, tingling, or burning. In some cases the numbness, loss of taste, and altered feeling may be permanent and require special surgical procedures in an attempt to reverse the condition (rare occasion). For some children the temporary sensation of "numbness" may be fascinating and may suck, bite, pull, or chew the area. We strongly caution you to observe your child during this time and prevent them from harming themselves.

_____
Initial

Filling/Restoration: A restoration is usually placed in teeth that have small cavities. Following the removal of decay from the tooth, the tooth is "filled" with a filling material. The filling materials used are amalgam (silver), composite resin (white), or other materials that have been explained to you by the doctor. The benefit of restoring decayed teeth is to allow a tooth to be saved that would ultimately need to be removed due to pain and/or infection. The timely restoration of teeth by fillings is the least expensive way to maintain the dental arch and oral health.

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Initial

Prophylaxis, Fluoride & Fluoride Varnish: Plaque is a mixture of food particles, saliva, and bacteria. If plaque is not removed from teeth it can lead to tooth decay (cavities) and irritation of the gum tissue making it tender, red, and bleed easily (gingivitis). If left untreated it may result in bad breath, yellow teeth, and bone loss (periodontitis). Dental cleanings can remove most stains; however, the success of the cleaning depends upon the quality of home care and oral hygiene. After the cleaning, fluoride treatment is done which strengthens the teeth and helps to prevent cavities. Your child should refrain from eating or drinking for at least 30 minutes to allow time for the fluoride to take its action. If excess fluoride is ingested, vomiting may occur.

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Initial

Extraction: Following a tooth extraction there may be post-operative bleeding, swelling, discomfort, and infection, as well as stiff or sore jaw joints and limited opening of the mouth. There may be loss of feeling in the lips, tongue, and surrounding tissue that may be permanent and require special surgical procedures in an attempt to reverse the condition. During the extraction, adjacent teeth may be damaged. Some tooth fragments may stay in the gums which may work their way through the gum tissue during healing or may have to be removed if they become infected. Failure to extract a tooth that needs to be removed may cause infection of both the bone and soft tissues and in extreme cases, may be life threatening.

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Initial

Sealants: Sealants are plastic coatings that are bonded to the chewing surfaces of posterior teeth to cover the grooves. Sealants make the surface of the tooth smooth and make it easier to clean effectively by brushing. Sealants help to prevent cavities but do not replace brushing and flossing. Sealants may need to be replaced or fixed periodically. The placement of sealants does not guarantee the teeth to be free of decay.

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Initial

Pulp Treatment: Pulp treatment in primary teeth is similar to root canal treatment in adult teeth. The pulpal portion of the nerve is exposed, removed, and filled with medicament. Pulp treatment is not always successful and it is an attempt to save the primary tooth for as long as possible. Failure of a pulp treatment may result in infection, pain, and extraction of the tooth. Following pulp treatment, the tooth needs to be restored with a crown which will greatly minimize the risk of bacteria re-entering the tooth.

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Initial

Crown: Crowns are used to completely cover the tooth that had pulp treatment, or a tooth that has been weakened by decay. Crowns are also commonly used to restore a tooth that is cracked, discolored, or damaged. Crowns will improve the strength and appearance of the tooth. Crowns may be stainless steel (silver), resin (white), or other materials which the doctor has explained to you previously. The crown must be brushed and cleaned while brushing other teeth. Sticky foods such as caramels, taffy, and chewing gum can pull the crown off. If this should occur, do not lose the crown. Simply schedule a re-cementation of the crown.

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Initial

Space Maintainer: Space maintainers are needed with a primary tooth is lost prematurely due to decay, infections, or trauma. The space left needs to be maintained for the permanent tooth to erupt in the correct position. Space maintainers do not guarantee prevention of orthodontic treatment in the future. Plastic teeth may be used to cover the empty space (pedo-partial) at the discretion of the doctor. Space maintainers are cemented in the mouth by temporary cement and may become loose with time. Care must be taken to avoid loss or damage to the space maintainer. Sticky foods such as caramels, taffy, and chewing gum can pull the space maintainer off as well.

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Initial

Mouth Prop: Mouth props are a hard plastic and sometimes metal instrument that helps to keep the mouth open during treatment. The use of the mouth prop prevents TMJ pain, discomfort, closing of the mouth during treatment, and accidental biting of objects. Mouth props are considered a restraint.

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Initial

Every reasonable effort will be made to treat your child's condition properly and safely, although it is not possible to guarantee results of treatment. By signing below you have read this document, understand the information about the proposed treatment, and have had all your questions fully answered, and authorize treatment to be done.

_____	_____	_____	_____
Patient's signature (Parent if patient is a minor)	Child's name	Date	Dentist's signature