CANTRELL FAMILY DENTISTRY

PARENT INFORMATION

CHILD'S NAME_____ BIRTHDATE_____ MALE ☐ FEMALE ☐

CHILD'S NAME_____ BIRTHDATE_____ MALE ☐ FEMALE ☐

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CHILD'S NAME_____ BIRTHDATE_____ MALE ☐ FEMALE ☐

HAS ANY OTHER IMMEDIATE FAMILY MEMBER BEEN TREATED AT THIS OFFICE? ☐ YES ☐ NO _____
Name

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMAIL ADDRESS_____(HOME OR WORK? DAD, MOM, OR FAMILY?)

☐ **FATHER** ☐ **STEPFATHER** ☐ **GRANDFATHER** ☐ **LEGAL GUARDIAN**

_____
Last First Initial

SOCIAL SECURITY NO. _____ BIRTHDATE _____ ☐ Married ☐ Separated ☐ Divorced ☐ Single

ADDRESS _____ HM. PHONE _____
Street or P.O. Box City State Zip

PRESENT EMPLOYER _____ WK PHONE _____ CELL PHONE _____

NAME OF FIRM _____ OCCUPATION _____

ADDRESS _____
Street or P.O. Box Apt. City State Zip

DENTAL INSURANCE CO. _____ GROUP #/ID _____
(Info. Needed Only if Patient is Covered on This Policy)

ADDRESS _____
Street or P.O. Box Apt. City State Zip

☐ **MOTHER** ☐ **STEPMOTHER** ☐ **GRANDMOTHER** ☐ **LEGAL GUARDIAN**

_____
Last First Initial

SOCIAL SECURITY NO. _____ BIRTHDATE _____ ☐ Married ☐ Separated ☐ Divorced ☐ Single

ADDRESS _____ HM. PHONE _____
Street or P.O. Box City State Zip

PRESENT EMPLOYER _____ WK PHONE _____ CELL PHONE _____

NAME OF FIRM _____ OCCUPATION _____

ADDRESS _____
Street or P.O. Box Apt. City State Zip

DENTAL INSURANCE CO. _____ GROUP #/ID _____
(Info. Needed Only if Patient is Covered on This Policy)

ADDRESS _____
Street or P.O. Box Apt. City State Zip

Assignment and Release: I hereby authorize the insurance benefits to be paid directly to the dentist. I also authorize the dentist to release any information required for all claims. I acknowledge that I am financially responsible for all charges whether or not they are paid by insurance. A minimum service charge of $1.00 (not to exceed 1%) on all charges over 90 days old will be accessed.

If I desire credit to be extended to me and/or my family for services rendered, I am aware that a credit report may be obtained before credit is extended.

In the event of default of payment and or/failure to pay, I agree to pay the costs of collection including court costs and reasonable attorney fees to be determined by a court of law. (I understand and agree that)...Any legal action, arising under or related to this agreement, shall be brought and maintained exclusively in a state court of Thurston County, State of Washington, and the parties hereby submit themselves to the personal jurisdiction and venue of those courts for the purpose of any such action and hereby waive any defense related to personal jurisdiction, process or venue brought in those courts.

Signature of Parent/Legal Guardian_____ Date _____

CANTRELL FAMILY DENTISTRY

INFORMED CONSENT

CHILD'S NAME : _____ DATE OF BIRTH: _____

CHILD'S NAME : _____ DATE OF BIRTH: _____

CHILD'S NAME : _____ DATE OF BIRTH: _____

CHILD'S NAME : _____ DATE OF BIRTH: _____

1. I, _____, authorize Drs. Jonathan and Sarah Cantrell and/or such associate dentists/hygienists/assistants may be selected by him/her to perform the following diagnostic and preventative procedures: clinical exam, x-rays, prophylaxis, and fluoride application as well as other diagnostic procedures as the dentist deems indicated.
2. I recognize the need for my dentist to exercise his/her professional judgment on my behalf and I therefore specifically authorize my dentist to select alternate methods of treatment based on my condition as disclosed during the procedure(s) authorized by my execution of this form, including conditions which were unknown at the time of surgery or dental procedure(s) were begun.
3. I understand that there are certain inherent risks and consequences that may be associated with any surgical, dental or anesthetic/sedative procedure(s). I understand that not every conceivable hazard can be listed. I realize the following possibilities exist, however infrequent or rare: allergic reactions to medications, anesthetics, etc.; drug interactions and side effects; excessive bleeding (during the procedure and/or after the procedure); postoperative bruising and discomfort; blood clots anywhere in the body; postoperative infection of bone inflammation; possible involvement of the sinus of the upper jaw during removal of upper back teeth, requiring possible surgery for repair at a future date; possible involvement of the nerve with the lower jaw during removal of lower teeth, resulting in usually temporary but sometimes permanent numbness and/or tingling in the lower lip and/or tongue; fracture or dislocation of the jaw; bruising and or vein inflammation at the site of injections; damage to adjacent teeth, restorations and/or gum tissue. THESE ARE NOT PROBABLE RESULTS, THEY ARE STATISTICAL POSSIBILITIES.
4. Knowing these risks, I consent to the dental and diagnostic procedure(s) outlined above.

_____ _____

Signature of Parent/Guardian Date

456 Country Club Rd Wylie TX 75098 • Suite 104 • Phone 972.442.9139 • Fax 972.442.9061
www.cantrellfamilydentistry.com

CANTRELL FAMILY DENTISTRY

CONSENT FOR OTHERS TO BRING MY CHILD/CHILDREN

Child's Name _____ Birthdate _____

Child's Name _____ Birthdate _____

Child's Name _____ Birthdate _____

Child's Name _____ Birthdate _____

We understand that at times it is not possible for the parent or legal guardian of a child to bring him/her in for a scheduled appointment or for emergency treatment. You may give permission for others to bring your child by filling out the following. If you leave this section blank, **ONLY** a parent or legal guardian will be allowed to consent or schedule an appointment. I, as parent or legal guardian give my permission for:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

to bring my child to any dental treatments and sign any consents that are required at the time of service. Further, I will make sure the above individual(s) are aware of the medical history of my child and can answer all questions required for safe dental treatment. In addition, I understand that treatment plan changes may occur for a variety of reasons. I understand and agree that any treatment plan that may have been explained to me is subject to change and in some cases will change the fee(s) quoted to me. Lastly, I will make arrangements for the above individuals to bring any necessary insurance forms and/or payment for services rendered at each visit.

Parent/Legal Guardian Signature: _____ Date: _____

CANTRELL FAMILY DENTISTRY

PRACTICE TERMINOLOGY AND PARENT GUIDELINES

Dear Parents,

In order to improve the chances of your child having a **POSITIVE** experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by **NOT USING** negative words that are often used for dental care. These include:

DON'T USE	OUR EQUIVALENT
Needle or shot	sleepy juice
Drill	water whistle
Drill on tooth	clean a tooth
Pull or yank tooth	wiggle a tooth out
Decay, cavity	sugar bug or cavity bug
Examination	count teeth
Tooth cleaning	tickle teeth
Explorer	tooth counter
Rubber dam	raincoat or umbrella
Stainless Steel Crown	tooth hat
Gas (nitrous oxide)	magic air, space air, laughing gas

This will help you understand your child's description of the dental experience. Our intention is not to "FOOL" the child – it is to create an experience that is **POSITVE.** We appreciate your cooperation in helping us build a good attitude for your child!

In our experience we find that **MOST** children do better without parents present so we ask that you remain in the waiting room during your child's appointment. Being able to go back to the appointment by themselves helps give them a sense of confidence and self-assurance. It also gives the doctor more capability to focus on your child and form that good relationship with them in order to give them that **POSITIVE** experience. Although we understand if you choose to be present please discuss this with the doctor and we suggest the following guidelines to improve chances of a positive outcome.

1) Allow us to verbally prepare your child for the appointment
2) Be supportive of the practice's terminology
3) Please be a silent observer – you can support your child with touches
    A) This allows us to maintain communication with your child
    B) Children will normally listen to their parents instead of us and may not hear our guidance
    C) You might give incorrect or misleading information
4) If asked to leave, be ready to immediately walk away
    A) Many children try to control the situation
    B) "Acting out" is normal, but unacceptable during fillings or treatment of any kind
    C) This is intended to "short circuit" the control attempt
    D) We will continue to support your child at all times

These are very important ways that you can actively help in the success of your child's visit. We are confident that all will go well and hope these guidelines will help you prepare your child with confidence for the upcoming appointment.

Parent/Legal Guardian's Printed Name _____

Parent/Legal Guardian's Signature _____ Date_____

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