Welcome To WATERTOWN Dental Care

We are delighted and honored that you have chosen us to provide your child with the best dental care possible. We love ❤ to treat children in our practice!

The first visit to the dentist may be the most important one in your child's life. It's an experience that will help determine and motivate life-long dental health. That's why we go slowly, and take all the time your child needs to feel comfortable. We will do our very best to make your child's dental visit an enjoyable and positive experience. We promise to deliver the highest standard of care, and we welcome all of your questions. Rest assured, most of our team members have children of their own, and we think your children are just as precious as ours.

Whether or not you're allowed to enter the treatment area with your child is a common dental question many parents have -- and there's not always a cut-and-dry answer. The fact is, whether or not a parent or guardian accompanies their child to the dental operatory often depends on the child's individual situation. The American Academy of Pediatric Dentistry recommends that parents of older children remain in the waiting room when children are brought into the dental operatory. Infants and some young children may benefit from having one of their parents in the operatory with them, but it's usually in a child's best interest to be treated without parental interference. Studies have shown that children over the age of 3 often respond better to dental treatment when their parents aren't in sight.

Generally speaking, we invite you to stay with your child during the initial examination. During the initial visit, your toddler might sit on your lap, or next to you, in the dental chair to help put him or her at ease. On subsequent visits, typically most children will be more cooperative when unaccompanied by a parent or guardian. We can usually establish a closer rapport with your child when you are not present. Our purpose is to gain your child's confidence and overcome any apprehension towards dental treatment.

Of course, we understand that every situation is different. We have advanced training specific to meeting the unique dental needs of children, so you can feel confident that you're leaving your child in excellent hands. By allowing your child to enter the operatory without you, you're placing trust in our office and teaching your child to do the same.

As parents, we are often more apprehensive than our children when it comes to their appointments, so care must be taken not to appear overly concerned. For example, statements such as "Don't worry," or "It won't hurt," can do more harm than good. Children can sense parent's anxiety and discomfort. Using words of encouragement such as "This will be fun," or " It feels good to have healthy teeth," are just a few examples to help them understand that going to the dental office will be a positive experience.

We appreciate you choosing Watertown Dental Care to care for your family. We are passionate about Oral Health and love sharing that passion with all of our patients—young and old—and instilling a lifetime of oral health!

We look forward to meeting you.

Darin Bach, DDS, FAGD, Diplomate, American Board of Dental Sleep Medicine
Hally Bach, DDS
Clayton Conroy, DDS

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MINOR CHILD REGISTRATION

WATERTOWN Dental Care.com

Bach Sleep Center

"Giving You Something To Smile About"!

PATIENT INFORMATION (MINOR CHILD)

First Name: _____ MI ___ Last Name: _____

Nickname: _____Birthdate: _____SSN: _____ Sex: _____

PARENT INFORMATION (MOM)

First Name: _____ MI ___ Last Name: _____

Birthdate: _____SSN: _____ Sex: _____ Email: _____

Please Check One: ____Single ____Married ____Separated ____Divorced ____Widow Full Time Student: ___Y ___N

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

PARENT INFORMATION (DAD)

First Name: _____ MI ___ Last Name: _____

Birthdate: _____SSN: _____ Sex: _____ Email: _____

Please Check One: ____Single ____Married ____Separated ____Divorced ____Widow Full Time Student: ___Y ___N

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE

Primary Dental Coverage

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's DOB: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

Secondary Dental Coverage

Policy Holder's Name: _____

Relationship to Patient: _____

Policy Holder's DOB: _____

Policy Holder's SSN: _____

Policy Holder's Employer: _____

COORDINATION OF CARE

To serve you best, please provide the following contact information:

Primary Care Physician: _____ Sleep Doctor: _____

Previous Dentist: _____ Other Specialist: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Medical Power of Attorney: _____ (Please provide documentation)

MINOR CHILD REGISTRATION

COMMUNICATION

- Our office will help remind you and your family of upcoming appointments via Telephone or Email/Text. It is critical that we receive confirmation from you regarding your visit. Additionally, should rescheduling be necessary, kindly give our office THREE business days' notice. Once you opt into a confirmation method preference, please note that responding will prompt our systems that further attempts to reach you are not necessary.
  _____Telephone _____Email/Text

- May we contact you via your provided home and cell phone numbers regarding financial questions and information? ____Yes _____No

- How did you hear about our office? ___Mailed Offer ___Walk-In ___Website ___Facebook ___Phone Book ___Billboard

  ___Personal Referral (Name: _____) ___ Special Event

Missed Appointment Policy

Please help us to serve you and all our patients by keeping your scheduled appointments. If it is necessary to reschedule an appointment, please give us THREE business days' notice. _____(Parent Initial)

Insurance & Financial Policies

- In most cases, we are happy to accept assignment of insurance benefits from your insurance company. As a courtesy to you we will file your claim and help you maximize your benefits. We will provide an estimated coinsurance payment for treatment, which is due on the date of service. As this is an estimate only, you may have an additional balance due or we may issue you a refund after we have received payment from your insurance carrier. It is important to note that the balance on your account is your responsibility regardless of your carrier's coverage or lack of. You are responsible for knowing your own benefit details. _____(Parent Initial)

- I hereby authorize my insurance company to assign benefits directly to the office of Watertown Dental Care, PLLC. I understand that I am responsible for all costs of dental treatment. I authorize Watertown Dental Care to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I certify that the information I have provided on this Patient Registration form and the Medical and Dental Histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information to third party payors and/or other health professionals. I also authorize the use of my signature below on all insurance submissions. _____(Parent Initial)

- In order to make financial arrangements for your treatment, we offer several flexible options. We accept cash, checks, most major credit cards, Care Credit as well as short-term payment plans in the event of a denial for financing. By signing below, you understand and agree that you are financially responsible for all charges associated with this account. _____ (Parent Initial)

_____	_____	_____
Parent's Printed Name	Parent's Signature	Date

Summary Notice of Privacy Practices

Watertown Dental Care keeps information of all our dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this Notice.

You have a right to a copy of this "Notice" Please check your option below:

___I am requesting a copy of Watertown Dental Care's "Summary Notice of Privacy Practices".

___ I do not wish to receive a copy of the Watertown Dental Care's "Summary Notice of Privacy Practices" at this time. I reserve the right to request a copy at a later date.

I have had a full opportunity to read and consider the contents of this office's "Summary Notice of Privacy Practices". I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission.

_____	_____	_____
Parent's Printed Name	Parent's Signature	Date

MINOR CHILD REGISTRATION

Medicare

Is the patient covered by Medicare? _____No _____Yes If Yes, please see our office personnel for important information regarding your coverage.

Additional Items

Please provide us with a copy of a photo ID and your dental insurance card. We will utilize these items to verify and protect your identity.

DENTAL HISTORY

Is this your child's first dental visit? ____Yes ____No Is your child currently in pain? ____Yes ____No

Has your child ever had any unhappy dental experiences? ____Yes ____No If yes, please explain: _____

Date of Last Dental Visit: _____ Reason for Last Visit: _____ Date of Last X-Rays:_____

Has your child complained about dental problems? ☐ Yes ☐ No

Does your child brush his/her teeth twice daily? ☐ Yes ☐ No Does he/she require help? ☐ Yes ☐ No

Does your child floss his/her teeth daily? ☐ Yes ☐ No Does he/she require help? ☐ Yes ☐ No

Does your child drink fluoridated water? ☐ Yes ☐ No

Has your child received orthodontic treatment? ☐ Yes ☐ No If yes, Where? _____

Does your exhibit any of the following? (please circle)

lip sucking *chews on objects* *mouth breathing* *jaw pain* *sleeps with a bottle or sippy cup* *tongue thrust* *bed wetting*

nail biting *tongue/cheek biting* *speech problems* *uses pacifier* *clenching/grinding teeth* *snoring* *other: _____*

MEDICAL HISTORY

Is your child currently under the care of a physician? ☐ Yes ☐ No If yes, Please explain: _____

Has your child ever had surgery or been hospitalized? ☐ Yes ☐ No If yes, Please explain: _____

Is your child taking any medications, pills, vitamins, herbal supplements, etc.? (please list below)

_____

ALLERGIES (please circle): *Aspirin Penicillin Codeine Acrylic Latex Metal Food Local Anesthetics Other: _____*

Has your child had/experienced any of the following: (please circle)

Abnormal Bleeding	*Chicken Pox*	*Heart Murmur*	*Recurrent Headaches*	*Cerebral Palsy*	*Breathing/Lung Problem*
AIDS/HIV+	*Congenital Birth Defect*	*Hemophilia*	*Rheumatic Fever*	*Thyroid Disease*	*Mental/Physical Disability*
Allergies	*Congenital Heart Defect*	*Hepatitis*	*Seizures*	*Frequent Cough*	*Mitral Valve Prolapse*
Anemia	*Diabetes*	*High Blood Pressure*	*Scarlet Fever*	*Fainting Spells*	*Cold Sores/Fever Blisters*
Any Hospital Stays	*Endocrine System Disorders*	*Hives*	*Sickle Cell Anemia*	*Herpes*	*Blood Transfusions*
Any Operations	*Epilepsy*	*Kidney Problems*	*Sight Disorders*	*Leukemia*	*Disabilities*
Asthma	*Frequent Headaches*	*Liver/GI System Problems*	*Significant Injuries*	*Mononucleosis*	*Measles*
Autism	*Low Blood Pressure*	*Skin Rash*	*Convulsions*	*Tuberculosis*	*Cancer/Tumors*
Blood Disease	*Behavior/Learning*	*Lupus*	*Tonsillitis*	*Hearing Impaired*	*Anxiety*

Has your child ever 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 my child's health. It is my responsibility to inform the dental office of any changes to my child's medical status.

_____ _____ _____

Parent's Signature Parent's Printed Name Date

Dr. Signature & Date

Patient Form

healthystart™

Doctor: _____

Child's Name _____ Age _____ Date: _____

Filled Out By: _____ Relationship to Patient: _____

Sleep Disordered Breathing Questionnaire for Children

Earl O. Bergersen, DDS, MSD

The initial column should be filled out at first appointment, and the follow up column should be completed after 3 months of treatment. Please identify the following symptoms your child exhibits with the scale indicating severity of symptoms.

0 – Not Present 1 – 2 Mild 3 Moderate 4 - 5 Pronounced

Does your child:

	INITAL	FOLLOW UP	
1.	_____	_____	Snore at all?
2.	_____	_____	Snore only infrequently (1 night/week)
3.	_____	_____	Snore fairly often (2-4 nights/week)
4.	_____	_____	Snore habitually (5-7 nights/week)
5.	_____	_____	Have labored, difficult, loud breathing at night
6.	_____	_____	Have interrupted snoring where breathing stops for 4 or more seconds
7.	_____	_____	Have stoppage of breathing more than 2 times in an hour
8.	_____	_____	Hyperactive
9.	_____	_____	Mouth breathes during day
10.	_____	_____	Mouth breathes while sleeping
11.	_____	_____	Frequent headaches in morning
12.	_____	_____	Allergic symptoms
13.	_____	_____	Excessive sweating while asleep

	INITAL	FOLLOW UP	
14.	_____	_____	Talks in sleep
15.	_____	_____	Poor ability in school
16.	_____	_____	Falls asleep watching TV
17.	_____	_____	Wakes up at night
18.	_____	_____	Attention deficit
19.	_____	_____	Restless sleep
20.	_____	_____	Grinds teeth
21.	_____	_____	Frequent throat infections
22.	_____	_____	Feels sleepy and/or irritable during the day
23.	_____	_____	Have a hard time listening and often interrupts
24.	_____	_____	Fidgets with hands or does not sit quietly
25.	_____	_____	Ever wets the bed
26.	_____	_____	Bluish color at night or during the day
27.	_____	_____	Speech Problems *

*If yes, provide parent speech questionnaire

Was your reason for coming to this doctor for sleep or dental issues: _____

Based on Sahin et al, 2009; and Urschitz et al, 2004; AM Thoracic Soc Stand, 1996; Attanasio et al, 2010

Speech Questionnaire

To be filled out only if #27 was indicated above

Please check all that apply to your child:

	INITAL	FOLLOW UP	
28.	_____	_____	Is it difficult to understand your child's speech
29.	_____	_____	Difficult to understand over the phone?
30.	_____	_____	Nasal speech?
31.	_____	_____	Speech sounds abnormal?
32.	_____	_____	Others have difficulty understanding speech?

	INITAL	FOLLOW UP	
33.	_____	_____	Gets frustrated when people can't understand speech?
34.	_____	_____	Sometimes omits consonants
35.	_____	_____	Uses M, N, NG instead of P, F, V, S, Z sounds
36.	_____	_____	Hoarseness
37.	_____	_____	Lisp
38.	_____	_____	Any speech therapy?

How Long? _____

Based on Barr et al, 2007