Children's Dental Associates

Pediatric Dentistry

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Board Certified by the American Board of Pediatric Dentistry

(931) 381-9721 www.childrensdentalcolumbia.com

TELL US ABOUT YOUR CHILD

Name:_____

Name called:_____

Male Female Age:_____

Date of Birth:_____

Siblings/Ages:_____

School/Grade:_____

Child's Physician:_____

Physician Phone #:_____

Date of Last Physician Visit:_____

Child's SS#:_____

TennCare: Yes No

MOTHER'S INFORMATION

Name:_____

Address:_____

_____

Home #:_____ Cell #:_____

Employer:_____

Work #:_____ SS#:_____

Date of Birth:_____ DL#_____

Email Address:_____

Marital Status: Married Single Separated Divorced Widowed

FATHER'S INFORMATION

Name:_____

Address:_____

_____

Home #:_____ Cell#:_____

Employer:_____

Work #:_____ SS#:_____

Date of Birth:_____ DL#_____

Email address:_____

Who has legal custody of this child?_____

_____

Was your child adopted? Yes No

Other children in your family who have received dental care from this office: _____

_____

_____

Is this your child's first visit to a dentist? No Yes

If no, name of previous dentist: _____

Who may we thank for referring you? _____

Has your child had an unfavorable experience in a dental or medical office? Yes No

If yes, please describe:

_____

Has your child had any unfavorable reaction to medications including antibiotics and local anesthetics? Yes No

If yes, please describe: _____

_____

Please list the names, dosage and frequency of all medications your child is currently taking:

_____

_____

_____

Is your child being treated by a physician? Yes No

If yes, please describe: _____

_____

Home water source: City Well Spring

Does your child take fluoride supplements? Yes No

Does your child have any of the following? Please circle.

broken tooth	mouth injury	jaw pain
cavities	sensitive teeth	toothache
crooked teeth	mouth ulcers	fever blisters
thumb sucking	finger sucking	pacifier

Medical Conditions: Please Circle

anemia	asthma
attention deficit	autism
bleeding	blood transfusions
cerebral palsy	cleft lip/palate
diabetes	Down Syndrome
emotional problems	epilepsy
heart defect	fainting
hepatitis	HIV/AIDS
mental illness	liver/kidney
nervous disorder	mental retardation
seizures	rheumatic fever
tuberculosis	speech/hearing

Other:_____

PATIENT CONSENT (MINOR)

Dr. James Hutton and Dr. Heather Owens are committed to providing the best possible care for your child. Since your child is a minor, it is necessary that signed consent be obtained from the parent/legal guardian before any dental treatment can be performed.

Clinical

1. As the parent/legal guardian, I authorize Children's Dental Associates to perform all recommended treatment for my child.

2. I authorize Children's Dental Associates to take radiographs, study models, photos, and other diagnostic aids or materials as needed to make a thorough diagnosis. I authorize that these aids or materials may be released to third-party payors and/or other health professionals.

3. I authorize the use of anesthetics, sedatives, and other medication, as needed, and am fully aware that using anesthetic agents involves certain risks, including but not limited to redness and swelling of tissue, pain, itching, vomiting, dizziness, miscarriage, cardiac arrest, drowsiness, and/or lack of coordination.

Financial

4. I am responsible for payment for all services rendered on behalf of the Patient. I understand that payment is due when services are rendered.

5. I understand there will be a $29 fee for any returned checks and no future checks will be accepted for payment.

Insurance

The coverage provided by insurance companies varies from company to company. It is impossible for our office to know how much each company pays for each procedure and what they do not cover. Therefore, it is important for you to familiarize yourself with your insurance coverage. The fact that your insurance chooses not to cover a certain procedure does not mean that the procedure is not important for your child. As dental care providers, our relationship is with you and your child, not your insurance company. While the filing of insurance claims is a courtesy we provide for our patients, all charges are your responsibility from the time services are rendered. We will collect the computer-estimated portion plus any deductibles required by your insurance company. Our business office supervisor can assist you if you need financing for treatment.

6. I authorize Children's Dental Associates to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and radiographs about the Patient's medical history, services rendered, or recommended treatment.

7. I authorize the Practice to submit claims for payment of services rendered or pre-authorizations necessary to my insurance company, on my behalf or on my child's behalf and in my name listed as "signature on file" and assign to Children's Dental Associates insurance benefits providing assignment is accepted. I am responsible for payment regardless of the coverage my insurance provides.

Broken Appointments

8. I understand that 24 hours notice of cancellation is required and that my child may be dismissed from the practice if I miss 3 or more dental appointments without providing 24 hours notice.

Please list any procedures that you do NOT want to be performed on your child:

_____

_____

I do not hold Dr. Hutton or Dr. Owens responsible for any detrimental effects that result from the above procedure(s) not being rendered. I have read and understand the above information. I want the procedures rendered that represent the standard of care as presented by the American Academy of Pediatric Dentistry and the American Dental Association. I understand that should there be any procedure that I do not wish to be performed on my child, I must notify the office prior to my child's visit. By signing below, I am giving consent for Dr. Hutton or Dr. Owens to perform dental services for my child.

_____

Child's Name Date of Birth

_____

Signature of Parent/Legal Guardian

_____

Relationship to Child

_____

Date

***This form does not expire until the parent /legal guardian completes another "Patient Consent (Minor)".