



# Children's Dental Associates

Pediatric Dentistry

James L. Hutton, D.D.S. • Heather H. Owens, D.D.S.

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: \_\_\_\_\_

Email Address: \_\_\_\_\_

Marital Status: Married Single Separated  
Divorced Widowed

## FATHER'S INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Cell#: \_\_\_\_\_

Employer: \_\_\_\_\_

Work #: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Email address: \_\_\_\_\_

Who has legal custody of this child?  
\_\_\_\_\_

Was your child adopted? Yes No

Nearest relative not living with you: \_\_\_\_\_

Relationship to child: \_\_\_\_\_

Phone #: \_\_\_\_\_

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

Is this your child's first visit? Yes No

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 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

Has your child ever had any problems with the following?

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: \_\_\_\_\_

**PRIMARY DENTAL INSURANCE**

Insurance Co.: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_  
Subscriber's SS#: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_

**SECONDARY DENTAL INSURANCE**

Insurance Co.: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone #: \_\_\_\_\_  
Group #: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Relationship to Child: \_\_\_\_\_  
Subscriber's Date of Birth: \_\_\_\_\_  
Subscriber's SS#: \_\_\_\_\_  
Subscriber's Employer: \_\_\_\_\_

**GUARDIAN & FINANCIAL INFORMATION**

Dr. James Hutton and Dr. Heather Owens are committed to providing your child with the best possible care. They are Board Certified Pediatric Dentists. They adhere to the guidelines recommended by the American Association of Pediatric Dentistry and the American Dental Association.

Since your child is a minor, it is necessary that signed permission be obtained from the legal guardian before any dental treatment can be performed. Authorization is granted by signing below.

If you have insurance, we are eager to help you receive maximum allowable benefits. 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 dental procedure does not mean that the procedure is not important for your child. It is generally a way employers seek to minimize the cost of the company's insurance plan.

As dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we provide for our patients, all charges are your responsibility from the date services are rendered.

Payment for services is due at the time treatment is rendered. If, however, your child is covered by dental insurance, then you will be expected to pay an estimated portion at that time. We will discuss your child's treatment needs with you and answer any questions relating to your insurance that you may have.

Please list any procedure 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 not being rendered. I have read and understand the above information. I understand that certain dental procedures may not be covered by my insurance. 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 agree to pay for any expenses not covered by my insurance. I understand that should there be a 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 and Dr. Owens to perform dental services for my child.

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date