Children's Dental Associates of Columbia
931-381-9721
Info@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 SSN:_____
TennCare: Yes No

MOTHER'S/GUARDIAN INFORMATION

Full Name:_____
Address:_____
_____
Home #:_____Cell#_____
Employer:_____
Work #:_____SS#_____
Date of birth:_____DL#_____
Email address:_____
Marital Status: Married Single Separated
Divorced Widowed

FATHER'S/GAURDIAN INFORMATION

Full 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? Yes No
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

Dental Conditions: Please circle

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

Medical Conditions: Please Circle

anemia	asthma	ADHD/ADD
autism	bleeding	blood disorders
cerebral palsy	cleft lip/palate	developmental
Down Syndrome	emotional	epilepsy
heart defect	fainting	hepatitis
HIV/AIDS	mental illness	liver/kidney
nervous disorder	mental delay	seizures
rheumatic fever	tuberculosis	speech/hearing

Other:_____
_____
_____

Patient Consent (MINOR)

Children's Dental Associates is 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 release 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 $35 fee for any returned check and no future checks will be accepted for payment. Payment is due at the time services are rendered.
6. A 3.95% processing fee applies to debit and credit card payment transactions. The 3.95% fee is waived when paying by ACH, cash or check.

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 to 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 form 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 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 cancellations 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 procedure that you do NOT want preformed on your child:

_____

_____

_____

I do not hold Children's Dental Associates 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 preformed on my child, I must notify the office prior to my child's visit. By signing below, I am giving consent Children's Dental Associates to preform 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)"**