Pediatric Dentistry
OF CENTRAL GEORGIA

FILL OUT ONE FORM (FRONT AND BACK) PER FAMILY

Child(ren) _____

_____

Address _____

City _____ State _____ Zip Code _____

Mom Cell _____ Dad Cell _____ Home Phone _____

Email _____

Whom may we thank for referring you to our practice? _____

PARENT/GUARDIAN INFORMATION

Biological/Adoptive Mother/Guardian _____ Date of Birth _____

Address _____ SSN _____

Biological/Adoptive Father/Guardian _____ Date of Birth _____

Address _____ SSN _____

Step Mother _____ Date of Birth _____

Step Father _____ Date of Birth _____

Who does the child live with? _____

Is either parent active military? ☐ Yes ☐ No

Are the child's biological or adoptive parents married? ☐ Yes ☐ No

Are the child's biological or adoptive parents divorced? ☐ Yes ☐ No

Is there a divorce decree or custody order that states who must carry health insurance for the child(ren)? ☐ Yes ☐ No

*If there is a decree or order, we will need a copy of the relevant portion (not the entire order) stating who must hold insurance.

MEDICAL INSURANCE INFORMATION

Insurance Company _____ Policy # _____

PRIMARY DENTAL INSURANCE INFORMATION

Policy Holder _____ Policy Holder SS# _____

Insurance Company _____ Ins. Co. Phone # _____

Policy # _____ Group # _____

Employer _____

SECONDARY DENTAL INSURANCE INFORMATION

Policy Holder _____ Policy Holder SS# _____

Insurance Company _____ Ins. Co. Phone # _____

Policy # _____ Group # _____

Employer _____

CONSENT FOR TREATMENT

I am the parent or legal guardian of the minor child or children listed with this packet, and there are no court orders now in effect that prevent me from signing this consent. The information I have given is correct to the best of my knowledge. I fully understand that Pediatric Dentistry of Central Georgia, PC is relying on the information I have provided in agreeing to treat my child. It is my responsibility to inform Pediatric Dentistry of Central Georgia PC, of any changes in my child's medical status. I authorize Dr. Moore, Dr. Flournoy, Dr. Garrett and/or associates to perform any necessary dental procedures including but not limited to dental cleanings, sealants, fluoride, and any necessary x-rays needed on my child.

Parent/Guardian: _____ Date: _____

Print Name: _____

FINANCIAL INFORMATION

Pediatric Dentistry of Central Ga PC's policy requires payment in full at the time of service. For those families utilizing insurance benefits, we are happy to file your insurance claim as a courtesy. However, we do not have a contract with your insurance company. The type of plan chosen by you, and/or your employer, determines your insurance benefits. We are not responsible for how your insurance company processes claims and do not guarantee payment from them. We can only provide an ***estimate*** and it is ***expected at the time of treatment***. By law, your insurance company is required to pay each claim within 30 days of receipt. We file most claims electronically, so your insurance company will receive claims within a few days of your service with us. It is your responsibility as parent/guardian to pay any remaining balance on your account. Regardless of insurance payments, account balances not paid within 60 days will incur a re-billing fee and will be added to your account each month until it is paid. I hereby authorize all insurance benefits, if any, be assigned directly to Pediatric Dentistry of Central Georgia PC, otherwise payable to me for services rendered. I authorize the release of any information to process insurance claims, including the use of my signature, on all insurance submissions. I acknowledge I will be liable for all collection fees and any other expenses incurred while collecting the account balance. There is a fee of $50 for returned checks.

Parent/Guardian: _____ Date: _____

Print Name: _____

CONFIRMATION & MISSED APPOINTMENT POLICY

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and ***INDIVIDUAL*** attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time during our busy schedule, we must ask that parents arrive on time for their children's appointments. This allows us to be able to see all the children that are scheduled in a timely and efficient way. When a parent is *late* or *fails* to make a scheduled appointment, this may jeopardize all the children's treatment. It also affects other parent's schedules that have children scheduled after your child that day.

- Parents may change or cancel their child's appointment with at least a 24-hour notice.
- Appointments must be confirmed *24 hours in advance.* If you do not confirm the appointment, it will be moved off the schedule. Pediatric Dentistry of Central Georgia, PC will place a courtesy call prior to your appointment to answer any questions you may have.
- If a patient is more than 15 minutes late, we may need to reschedule the appointment. If we are able to see the child, we cannot guarantee that all treatment will be completed.
- There will be a $25 fee charged to your account for all appointments that are cancelled and/or broken within less than 24 hours. If your child is being sedated and you do not give 24 hours notice you will forfeit your deposit.
- After having 2 missed or broken appointments, we will no longer be able to provide your child dental care. If this happens, you will be notified by mail of your child's dismissal from the practice. We will continue to provide emergency dental care for your child for up to 30 days following the dismissal.

Parent/Guardian: _____ Date: _____

PLEASE FILL OUT ONE FORM (FRONT AND BACK) FOR EACH CHILD.

Name _____

Date of Birth _____ ☐ Male ☐ Female Hobbies _____

DENTAL HISTORY

Last Dental Visit: _____ Last Cleaning: _____ Last X-Rays: _____

Previous Dentist _____ Do you have a copy of x-rays? _____

My child brushes his/her teeth _____ times per day. Are you on well water? ☐ Yes ☐ No

Do you help your child brush his/her teeth? ☐ Always ☐ Sometimes ☐ Never

Does your child have any mouth habits? (Please circle all that apply)

Thumb/Finger Sucking Grinding during sleep Sleeping with bottle Pacifier

Other: _____

Does your child floss every day? ☐ Yes ☐ No
Is fluoride taken in any form? ☐ Yes ☐ No
Do you expect your child to be cooperative? ☐ Yes ☐ No
Does your child do well at hair appointments? ☐ Yes ☐ No

Any injuries to the mouth/teeth? ☐ Yes ☐ No Please explain: _____

Is there a history of bad dental experience? ☐ Yes ☐ No Please explain: _____

Is your child in pain today? ☐ Yes ☐ No Please explain: _____

Does your child have a dental condition about which you are especially concerned? _____

Any concerns you would like our team to be aware of before your child's first visit? _____

Child's Pediatrician _____ City/State _____

Pediatrician Phone # _____ Date of last exam: _____

Any health concerns? _____

MEDICAL HISTORY Child's Name _____ Weight _____

CURRENT ADDRESS/PHONE _____

Place a mark on yes or no for each of the following.

ADD/ADHD	☐ Yes ☐ No	Cleft Palate	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
AIDS/HIV	☐ Yes ☐ No	Cystic Fibrosis	☐ Yes ☐ No	Radiation	☐ Yes ☐ No
Acid Reflux	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	--Area/Last Treatment:	
Anemia	☐ Yes ☐ No	Down's Syndrome	☐ Yes ☐ No	Sensory Process Disorder	☐ Yes ☐ No
Asperger's	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting	☐ Yes ☐ No	Sickle Cell Anemia	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Sinus Problems	☐ Yes ☐ No
Bladder Issues	☐ Yes ☐ No	Hearing Loss	☐ Yes ☐ No	Skin Disorder	☐ Yes ☐ No
Bleeding Issues	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Speech Concern	☐ Yes ☐ No
Cancer/Tumors	☐ Yes ☐ No	Heart Valve Replacement	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Vision Loss	☐ Yes ☐ No
--Last Infusion:		Kidney/Stomach Disease	☐ Yes ☐ No	Other:	
Chronic Bronchitis	☐ Yes ☐ No	Learning Delay	☐ Yes ☐ No	**Girls:** Are you pregnant?	☐ Yes ☐ No

If you said yes for the following, please provide additional information:

Asthma When was your child's last attack? _____ Ever hospitalized? When? _____

Epilepsy When was your child's last seizure? _____ Ever hospitalized? When? _____

Surgery Has he/she ever has surgery? ☐ Yes ☐ No Why? _____

MEDICATIONS List any medications that your child is currently taking and the correlating diagnosis: _____

ALLERGIES ☐ NONE ☐ Penicillin/Amoxicillin ☐ Latex ☐ Aspirin ☐ Sulfa ☐ Metal ☐ Local Anesthetic

☐ Other - List _____

SIGNATURE: _____ (signature) _____ (date)

SIGNATURE: _____ (signature) _____ (date) _____ (UPDATED weight)

SIGNATURE: _____ (signature) _____ (date) _____ (UPDATED weight)

SIGNATURE: _____ (signature) _____ (date) _____ (UPDATED weight)

SIGNATURE: _____ (signature) _____ (date) _____ (UPDATED weight)