Patient Information

Child's Name: ______________________________ Child's DOB: ______________

Preferred/Nickname (If Applicable): ______________________ Child's Sex: ☐ Male ☐ Female

Child's school/daycare: ____

Favorite activities/hobbies/pets: ______________________________________

Parent Information

Parent 1 Name: ____________________ Parent 2 Name: ____________________

Parent 1 SSN: ____________________ Parent 1 SSN: ____________________

Parent 1 Cell #: ____________________ Parent 2 Cell #: ____________________

Parent 1 DOB: ____________________ Parent 2 DOB: ____________________

Parent 1 Marital Status: ____________________ Parent 2 Marital Status: ____________________

Parent 1 Employer: ____________________ Parent 2 Employer: ____________________

Who brought the child today?: __________________ Are you the child's guardian?: ______________

Social notes (adoption, guardianship, etc.) if applicable: ______________________________

Cell phone number: ____________________ Other phone number: ____________________

Email Address: ____

Home address: ____

City: ____________________ State: ______________ Zip Code ____________

Is there anything we should know that we have not asked above? ______________________________

____

How did you hear about us?

☐ Referred by friend ☐ Drive By ☐ Google ☐ Facebook

☐ Referred by a dentist ☐ Referred by medical doctor ☐ Other: ____________________

Insurance Information

Primary Dental Insurance		**Secondary Dental Insurance (If Applicable)**	
Name of Insured:		Name of Insured:	
DOB:		DOB:	
SSN:		SSN:	
Employer:		Employer:	
Phone:		Phone:	
Insurance Company:		Insurance Company:	
Company Phone:		Company Phone:	
Group/Policy #		Group/Policy #	
ID #		ID #	

Patient Name: ______________________ **DOB:** _______________

Medical History

☐ Yes ☐ No Has your child ever had any health problems? ____________________

☐ Yes ☐ No Were there any difficulties at birth? ____________________

☐ Yes ☐ No Does your child have any allergies? ____________________

☐ Yes ☐ No Are your child's immunizations current?

☐ Yes ☐ No Have you ever been told that your child needs to take antibiotics before dental treatment?

☐ Yes ☐ No Has your child ever been hospitalized, had general anesthesia, or previous surgeries? Please explain:

____

Medications your child is taking: ____________________

Child's physician and clinic: ____________________

Child's Height: ______________ Child's Weight (lbs): ______________

Please check if your child currently has, or been treated for any of the following:		
☐ Allergic reaction	☐ Cerebral palsy	☐ Kidney disease
☐ ADD/ADHD	☐ Cleft lip/palate	☐ Mental or behavior delays
☐ Anemia	☐ Congenital birth defect	☐ Physical or growth delays
☐ Anxiety or depression	☐ Diabetes or endocrine problem	☐ Seizures or neurological problem
☐ Asthma or respiratory	☐ Gastro-intestinal issue	☐ Snoring or sleep apnea
☐ Autism spectrum	☐ Genetic syndrome	☐ Speech or hearing problem
☐ Bleeding disorder	☐ Heart problem or congenital defect	☐ Tonsils or adenoids
☐ Cancer/chemo/radiation	☐ Infection	☐ Tobacco or substance abuse
☐ Other, or please expand further:		

Dental History

What brings you to our office today? ____________________

☐ Yes ☐ No Has your child ever seen a dentist, and if so, when? ____________________

☐ Yes ☐ No Were x-rays or other treatment completed? ____________________

☐ Yes ☐ No Any existing dental conditions or concerns? ____________________

☐ Yes ☐ No Is your child having tooth pain? ____________________

☐ Yes ☐ No Has your child experienced dental trauma? ____________________

☐ Yes ☐ No Does your child have any oral habits (thumb, pacifier)? ____________________

Please describe home hygiene/brushing: ____________________

Please describe fluoride exposure: ____________________

Do you have any concerns or special requests for the Doctor? ____________________

How do you anticipate your child will behave for today's appointment?

☐ Cooperative ☐ Anxious, but probably cooperative ☐ Uncooperative or crying ☐ Unsure

Patient Name: ______________________ **DOB:** _______________

Consent for Treatment and Release of Protected Health Information

I give my consent for Dr. Connor W. McCall at Clinch River Pediatric Dentistry to examine, clean, diagnose, and provide dental treatment on my child's teeth that may be deemed necessary, in accordance with accepted standards of pediatric dental care. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Connor W. McCall to diagnose and/or treat my child's dental needs. I understand and approve for the doctor and staff at Clinch River Pediatric Dentistry to use appropriate behavior management strategies in order to safely guide patient behavior and complete the needed dental work. This may include using positive reinforcement, explanation, and using variable voice tone body language, and other techniques that are reasonable, necessary, and advisable.

Initial: _________ **Date:**__________

By initialing below, I authorize Clinch River Pediatric Dentistry to disclose my child's protected health information (PHI), which may include sending films and/or reports containing my child's PHI (consisting of name, date of birth, medical history, clinical notes, radiographs, photos etc.) to any other physicians or healthcare providers that request or require this information to perform treatment and/or consultation regarding my child's dental health. To facilitate the filing of my dental insurance claims, I also authorize the release of PHI to my dental insurance agency and any of their representatives. I authorize Clinch River Pediatric Dentistry to leave voicemail, email, and text messages to confirm, change or notify me of my appointment, unless specifically requested otherwise. I understand that these messages may contain PHI about my child.I have been informed that Clinch River Pediatric Dentistry has a more detailed form available upon request. This more detailed version can be provided at any time.

Initial: _________ **Date:**__________

Failed Appointment Policy

We strive to provide excellent dental care to all of our patients and reserve time on the schedule specifically for your child. To be fair to all patients wanting to be seen here, we require advanced notice of changes so unused appointment time can be offered to another patient. In the event that we are not given 24 hours notice for a cancellation, we may not be able to reschedule your child or your family at our office in the future. A failed appointment without calling our office may be grounds for dismissal from the practice.

Initial: _________ **Date:**__________

Accompany Minor

The following individuals may accompany and/or authorize dental treatment for this minor patient, and act on my behalf to make health care decisions. This permission applies to telephone and answering machine services, as well as other means of communications. I understand that Clinch River Pediatric Dentistry reserves the right to postpone the delivery of certain treatments when a legal guardian is not present.

Name	Relationship to Patient	May authorize a Change in Treatment	Phone Number
		Yes / No	
		Yes / No	
		Yes / No	

Marketing Photo Release

☐ Yes ☐ No I consent for my child's photographs to be used for marketing and educational purposes.

Initial: _________ **Date:**__________

Patient Name: ______________________ **DOB:** ______________

Insurance Disclaimer

As a courtesy to you, we will file an insurance claim for services we provide. However, it is your responsibility to know your insurance benefits. You should know the following things about your plan:

Individual or Family Deductible Amount   Waiting Periods   Benefits Details

Every policy is individualized - you may have the same insurance company as someone else, but each policy contains different benefits. We will file a pre-estimate of any treatments you need, but not all insurance companies provide that information.

Because of the 2003 HIPAA regulation (Health Insurance Portability and Accountability Act), insurance companies now have disclaimers protecting individual information. An authorization number for procedures is not a confirmation of coverage or benefits. If our office recommends a procedure or x-ray, etc., **we do not always know if this is a covered expense under your plan.**

If your insurance changes, it is important that you give us complete and accurate information prior to your procedures. **Please do not give us a phone number and expect us to gather your information.** We will refund you if your insurance pays more than we estimate, or bill you for the remainder.

I have read and understand the Insurance Disclaimer.   **Initial:** ________ **Date:**__________

Financial Policy

A. I hereby authorize payment of insurance benefits to the dentist otherwise payable to me.
B. I understand that the treatment plan presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above named patient.
C. Payment is expected when services are rendered either by cash, check, credit card, or dental insurance
D. Assignment is accepted on dental insurance with the patient paying their estimated portion at the time of service. You will be billed for any balance not reimbursed by your dental insurance. We will also reimburse you in case of any overpayment.
E. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for for costs of collection, reasonable attorney fees of 25% of the amount owed, and interest from the date of service to payment at the legal rate.

Initial: ________ **Date:**__________

Appointments

We will attempt to give you an appointment that is convenient for you, but it is usually better to see younger patients in the morning. We try to confirm appointments the day before and would appreciate it if you could give us the best number to contact you. If you are unable to keep your appointment, we will request that you give us 24 hours notice so someone else may use your time. We reserve the right to charge a fee for appointments broken with no attempt to contact the office. Additionally, a failed appointment without calling our office may be grounds for dismissal from the office. Thank you for allowing us to provide your child's dental care. We appreciate the referral of your family and friends.

Signatures

Parent/Legal Guardian Signature: ______________________________ Date: ______________

Relationship to Child: ______________________________________