THE CHILDREN'S DENTIST, 271 STONECROSSING DRIVE, CLARKSVILLE, TN 37042
931-551-4400

The following information and history are necessary for adequate treatment and understanding of your child. Thank you for completing it in full.

Patient's name:_____Preferred Name:_____ Age:_____

Sex:_____Date of Birth:_____Race:_____Place of Birth:_____

Patient's address:_____Zip:_____

Home Phone:_____Cell Phone:_____

Child's Physician_____Phone Number:_____

Siblings / Ages:_____ e-mail address:_____

HEALTH HISTORY

	Yes	No		Yes	No
Is your child in good health?	___	___	Chronic cough?	___	___
Does your child have regular medical exams?	___	___	Vision disorder?	___	___
Up to date with immunizations?	___	___	Hearing disorder?	___	___
Presently taking medicines?	___	___	Recurrent mouthsores?	___	___
If so, what?_____			Blood transfusions?	___	___
Experienced a bad reaction to medicine?	___	___	Chemotherapy?	___	___
If so, what?_____			Transplant surgery?	___	___
Presently undergoing medical treatment?	___	___	Drug allergy?	___	___
If so, for what?_____			Latex allergy?	___	___
Child hospitalized since birth?	___	___	Dye, food allergy?	___	___
Date:_____Reason:_____			Heart Murmur?	___	___
Child have any infectious diseases?	___	___	Heart Condition?	___	___
If yes, list:_____			Lung Problem?	___	___
Brain injury?	___	___	Liver problem?	___	___
Kidney problem?	___	___	Epilepsy?	___	___
Diabetes?	___	___	Cerebral palsy?	___	___
Bleeding disorder?	___	___	Sickle Cell Anemia?	___	___
Hepatitis?	___	___	Tuberculosis?	___	___
Asthma?	___	___	Allergies?	___	___
Special needs?	___	___	Speech disorder?	___	___
Mental disorder?	___	___	Emotional disorder?	___	___
			Autism?	___	___

Other?_____

DENTAL HISTORY

	Yes	No		Yes	No
Is this your child first dental visit?	___	___	Breast Fed?	___	___
Date of last visit?_____			Bottle Fed?	___	___
Ever had serious/difficult problem with			Age stopped bottle or breast	_____	
Dental treatment?	___	___	Is water fluoridated?	___	___
If yes, please explain_____			Taking fluoride supplements?	___	___
Child have any of the following?			Discolored teeth?	___	___
Thumb/ lip sucking	___	___	Sensitive teeth?	___	___
Pacifier?	___	___	Jaw pain?	___	___
Toothache?	___	___	Crooked teeth?	___	___
Cavities?	___	___			
Broken tooth? Date:_____	___	___			

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment._____

I CERTIFY THE ABOVE INFORMATION IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION COULD BE DANGEROUS TO MY CHILD'S HEALTH. I AUTHORIZE THE CHILDREN'S DENTIST PC TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO MY CHILD DURING SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS.

Printed Name:_____Signature:_____

Date:_____Relationship to patient:_____

Doctor Signature:_____

THE CHILDREN'S DENTIST Insurance Information Page

PATIENT'S NAME:_____

MOTHER / STEP MOTHER / GUARDIAN

Name: _____

Address:_____ __

City:_____State:___ ZIP_____

Work #: _____Home #_____

Employer: _____

Employer Address:_____

_____ZIP:_____

DOB:_____

SSN #:_____

Parent's e-mail address:_____

FATHER / STEP FATHER / GUARDIAN

Name: _____

Address:_____ ___

City:_____State:____ZIP:____

Work #: _____Home #_____

Employer: _____

Employer Address:_____

_____ZIP:_____

DOB:_____

SSN #:_____

Parent's e-mail address:_____

My signature below allows insurance to be filed and payment to be made directly to the provider. I agree to be responsible for co-payments [or full fee, if not insured] at the time of my appointment. I understand that my insurance policy is between the insurance company and myself. **We are providers in network for: UCCI, Delta Dental and TennDent.**. *All other insurance company claims will be filed as a courtesy to you*. Payment is ultimately my responsibility, and I will make timely payments on any portion that is not covered by insurance. I authorize the release of any medical or other information necessary to process this claim.

PERSON BRINGING PATIENT TO APPOINTMENT IS RESPONSIBLE FOR ACCOUNT:

INSURANCE INFORMATION

Name of Insured [parent/guardian]_____Relationship to Patient: _____

Birth date [parent/guardian]_____

Primary Dental Insurance Company Name: _____

Group #_____Subscriber ID#_____

Address of Primary Dental Insurance Company: _____Zip:_____

Secondary Dental Insurance Company Name: _____

Group #_____Subscriber ID#_____ __

Address of Secondary Dental Insurance Company: _____Zip:_____

TennCare: ____yes_____no TennCare Insurance Company Name: _____

CHILD'S SSN: _____[For TennCare Only]

Who has legal custody of this child?_____

Phone number for confirmation of appointments:_____

I agree to diagnostic procedures and dental treatments as deemed necessary and desirable for the above named patient. I also understand that multiple missed appointments and failure to pay dental bills in a timely fashion will result in dismissal of the children from the practice. **My signature also indicates that I agree to pay a $50.00 fee for dental appointments that are not cancelled or rescheduled within 24 hours of appointment time.**

Signed:_____ Date:_____

FINANCIAL POLICY
THE CHILDREN'S DENTIST

Payment in full is expected on the day of service by cash, check, VISA / MasterCard or Care Credit. *The parent or guardian who brings the child into the office for dental treatment is financially responsible regardless of dental insurance or legal responsibility.*

For an in office oral sedation, there is a **$180.00 fee**. A **$60.00** deposit is required to schedule the sedation appointment with the balance due at the completion of the procedure. All dental sedation procedures are invasive procedures and require the uninterrupted attention of the doctor. During the sedation appointment, no other children are scheduled for the doctor so that he can devote the entire allotted time to your child.

Complex cases financial arrangements will be discussed prior to the first treatment visit. Dental cases performed at Surgical Care Affiliates require a **refundable $250.00 administrative fee that will be held as a credit to your account** in order to schedule the procedures. Our office will make every effort to provide an estimate of the dental expenses. The patient responsibility must be paid prior to treatment at the same day surgery center.

There is a non-sufficient check charge of **$25.00** and interest on past due accounts [30 days old] is 1.5% APR. All accounts 60 days past due may be processed on to AWA collections. If sent to collections, patients will be dismissed from the practice, no exceptions.

Cancellation Policy:

Dental treatment appointments are scheduled for a specific amount of time with the doctor. Arriving more than 15 minutes late may result in your appointment being rescheduled. As a courtesy to the doctor and so emergency patients can receive immediate care, we require a twenty-four hour notice of change or cancellation of your appointment. There is a **$25.00 missed appointment fee per child, up to $100.00** that may be imposed if the appointment is not rearranged before the 24-hour time limit. Please be considerate and reschedule your child's appointment!

Insurance: We are participating providers for BCBST, DELTA DENTAL, UCCI and DENTAQUEST [TennCare]. We have special arrangements for Active Duty dependents [ask for details]. Please contact your insurance provider for in / out of network benefits.

Patient Agreement:

I have read the above policy and understand my financial responsibility.
In any event this account is referred to an outside agency, credit reporting bureau, or attorney for collection, I agree to pay all attorney fees, collection costs, court costs, and/or any other expenses incurred in its collection, according to 1989 statues of the State of Tennessee.

Signature of Parent/Guardian:_____Date:_____

THE CHILDREN'S DENTIST
AUTHORIZATION FOR DENTAL TREATMENT

Patient's name: _____

I, being the parent or guardian of the above minor patient, hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures Drs Deeds, Weaver, and Deeds may deem necessary during treatment. If a child is under the age of eighteen, a parent, guardian or someone possessing a power of attorney must accompany them with the parent's permission.

I understand that Lary Deeds DMD, R. Michael Weaver DDS, Sarah Deeds DMD and such assistants as they may designate to treat the above-mentioned patient, will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics, which may be deemed advisable by Drs Deeds, Weaver and Deeds. I also consent that The Children's Dentist may use my dental radiographs or clinical photographs for the patient records.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology.

I agree to diagnostic procedures and dental treatments as deemed necessary and desirable for the above named patient.

Signature: _____Date: _____

The Children's Dentist

Your Privacy Is Important To Us

Acknowledgement of Receipt of Notice of Privacy Policies

I have received a copy of the Notice of Privacy Practices of _____TCD_____. I hereby authorize, as indicated by my signature below, _____TCD_____ to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Print Name Address

_____ _____

Signature Date

Please check your preferred means of communications:

- You may contact me at my home telephone number _____
- You may contact me on my mobile telephone number _____
- You may contact me on my work telephone number _____
- You may send me an email at _____
- Other _____

Please list authorized persons with whom we may discuss your Protected Health Information [PHI] in addition to custodial parents and legal guardians. **This form is NOT a substitute for a legal medical Power of Attorney.**

1. _____Date Added / Removed: _____
2. _____Date Added / Removed: _____
3. _____Date Added / Removed: _____

For Office Use Only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgement
An emergency situation prevented us from obtaining the acknowledgement
Other [Please Specify] _____
Staff Person Initials _____