IMPLANT & GENERAL DENTISTRY OF MIDDLE TENNESSEE

WELCOME to our office.

We want your child to have a pleasant yet educational visit. Our goal is to teach good oral care that will enable your child to have a beautiful smile that will last a lifetime.

Tell Us About Your Child

Today's Date:_____

Child's Name:_____
Last First MI

Nickname:_____

Child's Birthdate:___/___/___ Child's Age:_____

School:_____ Grade:_____

Child's Home #:_____ SS #:_____

CHILD'S HOME ADDRESS

_____
APT/CONDO #

_____
CITY STATE ZIP

Person Responsible for Account

Name:_____ Relation:_____

Billing Address:_____

_____
CITY STATE ZIP

WK#:_____ Ext_____ HM #:_____

Email_____

Fax_____

Employer:_____

DL #:_____ SS #_____

Who will make appointments?

Name:_____ Relation:_____

WK #_____ Ext._____ HM # _____

Who is accompanying the child today?

Name:_____ Relation:_____

Do you have legal custody of this child? Yes No

Who may we Thank for referring you?_____

Other family members seen by us:_____

_____

Previous / Present Dentist:_____
(Please circle)

Last Visit Date:_____

Parent's Marital Status:
___Single ___Married ___Widowed ___Divorced ___Separated

Mother's Information: (__Step Mother__Guardian)

Name:_____ Relation:_____

WK #:_____ Ext:_____ HM #:_____

Employer:_____

SS #:_____ DL #:_____

Father's Information: (__Step Father__Guardian)

Name:_____ Relation:_____

WK #:_____ Ext:_____ HM #:_____

Employer:_____

SS #:_____ DL #:_____

Primary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #):_____

Insured's Name _____

Relationship to Patient:_____

Insured's Birthdate:___/___/___ & S.S.#:_____

Insured's Employer_____

Orthodontic Coverage? ___ Yes ___ No

Secondary Dental Insurance

Insurance Co. Name:_____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #):_____

Insured's Name _____

Relationship to Patient:_____

Insured's Birthdate:___/___/___ & S.S.#:_____

Insured's Employer_____

Orthodontic Coverage? ___ Yes ___ No

Why did you bring your child to the dentist today? _____

_____

Has your child ever had a serious/difficult problem associated with previous dental work? ___Yes ___ No

Is your child's water fluoridated? ___ Yes ___ No

Is the child taking fluoridated supplements? ___ Yes ___ No

Has your child ever had any pain /tenderness in their jaw joint (TMJ / TMD)? ___ Yes ___ No

Does your child brush their teeth daily? ___ Yes ___ No

Floss their teeth daily? ___ Yes ___ No

Child's Physician: _____

Phone #: _____ Date of last visit:_____

Is your child currently under the care of a physician? ___Yes___No

Please describe your child's current physical health:

___ Good ___ Fair ___ Poor

Please list all drugs that your child is currently taking: _____

_____

_____

Please list all drug materials that your child is allergic to: _____

_____

_____

Has your child ever had any of the following medical problems?

___Y ___N Heart Murmur	___Y ___ N Congenital Heart Defect
___Y ___ N Cancer	___Y ___N Convulsions/Epilepsy
___Y ___N Diabetes	___Y ___ N Abnormal Bleeding
___Y ___N Rheumatic Fever	___Y ___N Hearing Impairment
___Y ___N HIV+ / AIDS	___Y ___N Any Operations
___Y ___N Hemophilia	___Y ___N Any stays in a hospital
___Y ___N Asthma	___Y ___N Kidney / Liver Problems
___Y ___N Hepatitis	___Y ___N Handicaps / Disabilities
___Y ___N Tuberculosis (TB)	___Y ___N Allergies to any drugs

Please discuss any serious medical problems your child has had:

_____

_____

_____

Does your child have any of the following habits?

___Y ___N Thumb / Finger Sucking

___Y ___N Lip Sucking / Biting

___Y ___N Nail Biting

___Y ___N Nursing Bottle Habits

Our Office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I give consent to allow use of photos or movies of my child's mouth in dental publications or presentations. I also authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Office Use Only • Office Use Only • Office Use Only • Office Use Only • Office Use Only

I verbally reviewed the medical / dental information above with the parent/guardian & patient named herein.

Initial: _____ Date: _____

Doctor's Comments:_____

MEDICAL HISTORY UPDATE

1. Date: _____ Signature:_____ Comments:_____
2. Date: _____ Signature:_____ Comments:_____

Medication and Supplement Record

	What I am taking	**Form** (pill, injection, liquid, patch, etc.)	**Dosage**	**How Much and When**	**Use** (regularly or occasionally)	**Start/Stop Dates**	**Notes, Directions, Reasons for Use**
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							

**Be sure to include ALL prescription drugs, over-the-counter drugs, vitamins, and herbal supplements.*

IMPLANT & GENERAL DENTISTRY

WELCOME:
My staff & I appreciate the selection of our office to serve your dental needs. Our goal in this practice is to provide you with the optimal dental care; my diagnosis of your needs will be the same, as I would make for a member of my own family. The following is an explanation of our financial policies. If you have any questions, please ask.

APPOINTMENTS:
Our goal is to provide quality dental care in a timely manner. In order to do so we have implemented an appointment/cancelation policy. The policy enables us to better utilize available appointments for our patients in need of dental care. Appointments are in high demand. Therefore, if it is necessary to cancel your scheduled appointment we require that you provide us with 24 hours notice. Your early cancelation will give another person the possibility to have access to timely dental care. If an appointment is missed without 24 hours notice being given, you will be subject to a $30 cancelation fee.

FINANCIAL POLICIES:
Professional services are to be paid for on the day that they are rendered. If a service requires more than one visit (example: a crown), you may pay ½ of the fee at the start of treatment, with the balance to be paid in full once treatment is completed. For your convenience, we also accept Visa, MasterCard, American Express, & Discover. If extended payments are desired, this option is available through Wells Fargo Financial (6 months same as cash).
* *All OVERDUE ACCOUNTS WILL RECEIVE A $15.00 MONTHLY LATE FEE THAT BECOMES THE REPSONSIBILITY OF THE ACCOUNT HOLDER TO PAY.*
If your account is placed for collections, the undersigned agrees to pay all attorney & collection fees.

INSURANCE:
Our office policy is to bill your dental insurance carrier as a courtesy to you. **Although, you are responsible to pay your estimated portion on the day of service**. Once the carrier is billed, payment must be made in full within 60 days. If your insurance carrier does not remit payment in full with in 60 days, the balance is due in full by you. Since we are not a party to the agreement with your insurance carrier, it is not our policy to contact carriers to establish why they haven't paid differently than originally indicated.

* Please be advised that if you have treatment rendered that you would like to file with your medical insurance carrier, we *do not* file medical claims. We do not have access to medical diagnosis codes or treatment codes.

PHILOSOPHY:
Our goal is to provide the best dental service possible. Proper dental care enhances your well-being; we want you to feel good about yourself and your oral health. Please feel free to ask any questions. We are honored to serve you, other members of your family, & your friends.

I have read and agreed to the above policy.
Signature (Patient, Parent, or Responsible Party):_____Date:_____