All About Kids Pediatric Dentistry

Dr. Courtney Wilson & Dr. Melanie Nesbitt

Patient Registration

Date:_____

Patient's Name _____ Nickname _____ Birth date _____ Age_____Sex_____

Patient's Address _____ Contact Phone # _____

street city state zip

Father's Name _____ DOB_____ Mother's Name _____ DOB _____

Parent's Marital Status _____ Address (if different than above) _____

Father's Employer _____ Social Security # _____ Business Phone_____

Mother's Employer _____ Social Security #_____ Business Phone _____

Who Is Accompanying Child Today? _____ Relationship to child _____ Do you have legal custody of this child? Y / N

For Patient's Covered By Insurance

Subscriber's Name _____ Birth Date _____ Social Security # _____

Subscriber's Employer _____ Business Address _____

Name of Ins. Co. You Mail Forms To _____

Group # _____ Subscriber ID # _____

Dental History

Is this your child's first visit to the dentist _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

_____

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

_____

Does the child have any of the following habits?

Yes / No Lip Sucking / Biting

Yes / No Nursing / Bottle Habits

Yes / No Pacifier

Yes / No Nail Biting

Yes / No Thumb / Finger Sucking

Yes / No Grinding

Does your child brush teeth daily? Yes / No

Do you assist child with tooth brushing? Yes / No

Is dental floss used? Yes / No

Any injuries to head- mouth- neck Yes / No

Is the child's water fluoridated? Yes / No

Is the child taking fluoride supplements? Yes / No

Does your child take any fluoride supplements? Yes / No

Has the child ever had a serious or difficult problem associated with dental work Yes No If yes, please explain _____

_____

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMD/TMJ)? Yes No

3285 Hacks Cross Rd Suite 101 Memphis, TN 38125

www.pediatricdentistmemphis.com 901.759.0970 info@pediatricdentistmemphis.com

Health History

Child's Physician _____ Address _____ Phone _____

Has Child Had Any History Of Any Of The Following:

Y N Abnormal Bleeding	Y N Congenital Birth Defects	Y N Autism	Y N Rheumatic/Scarlet Fever
Y N Allergies to any Drugs	Y N Seizures/Epilepsy	Y N Disabilities/Special Needs	Y N Allergies to Latex Product
Y N Any Hospital Stays	Y N Pregnancy	Y N Hearing Impairment	Y N Diabetes
Y N Any Operations	Y N Tuberculosis	Y N Heart Disease/Murmur	Y N Kidney/Liver Conditions
Y N Asthma	Y N ADD/ADHD	Y N Hemophilia/Blood Disorders	Y N Ear Aches/Infections
Y N HIV + / AIDS	Y N Cancer	Y N Hepatitis	

***Please discuss any serious medical conditions the child has had** _____
_____
_____

***Please list all drugs the child is currently taking**_____
_____
_____

***Please list all allergies** _____
_____
_____
_____

In an effort to improve communications with our patients, All About Kids Pediatric Dentistry will be E-mailing and/or texting appointment reminders. If you are interested in being part of this service, please enter your information below. Please be aware that this email address may also be used to email you personal information (ie.Receipts,Invoices,Letters) relating to your dental care. Your information is only used for communications with you and other dental professionals. We do NOT share or sell personal information.

Personal Email:_____ Cell Phone Number:_____

I hereby authorize the dentists and staff at All About Kids Pediatric Dentistry to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. (I authorize my insurance company to pay All About Kids Pediatric Dentistry all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment services charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of All About Kids Pediatric Dentistry. This consent is to remain in effect from the date indicated until canceled in writing.

Authorized Signature _____Relationship to Child _____ Date_____

For Office Use Only

I verbally reviewed the medical /dental information above with the parent/guardian:

Initials _____ Date_____

Doctor's Comments _____
_____
_____

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***APPOINTMENT CONFIRMATION POLICY ***

-All About Kid's Pediatric Dentistry **confirms all appointments via text/e-mail.**

-Please be sure we have a valid e-mail and cell phone number on file for you. If your information changes, please inform our office. **If we do not receive a confirmation reply to the text/ e-mail regarding your scheduled appointment, your appointment may be cancelled**

Preferred cell for TEXT messages: _____-_____-_____

_____
Preferred e-mail address

APPOINTMENT CANCELLATION POLICY

Our desire is to provide you and your child with the highest quality service and dental care in a caring and enjoyable atmosphere. We value your time and strive to maintain your appointment at the allotted time; in return we request the same from you. We **require at least a 2 business day notice** to cancel or reschedule an appointment. Unfortunately, as a result of a significant increase in short notice cancellations and no showing of appointments it has become necessary for us to enforce the following policy.

Failure to provide adequate notice may result in the following: INTIAL BELOW

_____If you are late for your appointment, it may be necessary for you to be reschedule and that appointment will be considered a cancellation without adequate notice.
_____ a **$25.00 fee** may be accessed to your account and must be paid before being rescheduled.
_____ Single patient scheduling, only one family member scheduled at a time
_____ **DISMISSAL** from the practice, **Emergency Dental Care ONLY** will be provided for a period of 30 days from the date of notification and in the future the patient(s) will need to seek dental care at another facility.

**Thank you for your understanding that we are committed to being available to as many children as possible who need our dental services. **

I HAVE READ AND UNDERSTAND THE POLICIES ABOVE:

Signature _____ Date _____

Patient Name _____ Relationship to Patient _____

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POLICY ON PARENTAL PRESENCE

At **All About Kids Pediatric Dentistry**, our goal is to make you and your child's visit as enjoyable, fun, and comfortable as possible. For children that are 4 years and older, we ask that you allow your child to accompany our staff through the dental experience. **We are highly experienced in helping children overcome apprehension.** Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own and in an environment designed for children. If this is your child's 1st visit, you will be given the chance to meet the doctor and tour our facility prior to the completion of the appointment.

It is very normal for children to be scared and apprehensive. We are trained to handle this. We ask that when children are receiving treatment with the dentist other than hygiene, that the parents wait in the front lobby. It has been our experience that children are more cooperative when the parent is NOT present. Please remember that our number one goal is the safety and comfort of your child. Whenever the doctor feels that the parent can help calm the child, a staff member will escort the parent to the treatment area. If you have questions or concerns regarding this policy, please feel free to speak with the dental assistant when your child is called back.

Please initial below:

_____ I understand that it is the policy of this office that parents of children 4 years and older are asked to remain in the front lobby.

_____ I understand that parents are NOT permitted in the restorative areas of the clinic.

_____ **I understand that at no time during my child's visit will I be permitted to leave the office, including but not limited to waiting outdoors or in my car. I must remain in the lobby AT ALL TIMES, while my child is being treated in the office.**

Signature _____ Date _____

Patient Name _____ Relationship to Patient _____

Media Authorization Form

From time to time, All About Kids Pediatric Dentistry may take promotional pictures to be used in the office, on our website, or on our Facebook page. The child will only be identified by first name, unless I give my expressed consent. I understand that there will not be any compensation given for use of these images. I also understand that I have the right to revoke this authorization by submitting a request in writing to the address above, and/or the right to refuse authorization by initialing below.

Child's Name:_____ Parent's Name (please print): _____

Parent's Signature Authorizing Use of Pictures Date***_____

******_____ I refuse authorization (initial)**

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FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. It is our policy to make financial arrangements with you before any treatment starts. Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask our staff.

1. The parent or guardian who brings the child to their dental visit is responsible for payment, independent of a divorce decree or custody arrangement. Reimbursement may be arranged between the parents, we will not intervene.
2. Payment for services rendered is due at the time of service. We accept cash, VISA, MC and CareCredit.
3. You must provide the office with a dental insurance card and the proper mailing address of the insurance companies. If these documents are not available, you may be responsible to pay for the charges in advance.
4. In the event we are unable to verify your dental benefits for **ANY** reason, you will be required to pay for the appointment in advance.
5. Our office will file ONLY primary insurance claims as a courtesy to you up to a maximum of 2 times. If after 30 days, the claim still remains unpaid, it will be closed and you will become responsible for the balance due and it will be your responsibility to seek reimbursement from your insurance carrier.
6. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and copayments at the time of service. You are responsible for paying all charges not covered by you insurance company, including all fees considered to be above your insurance companies usual and customary fee schedule. Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor.
7. The office cannot carry a balance longer than 90 days; regardless if the insurance payment is still pending. A $5.00 monthly rebilling charge will be added to your account if it is not paid within 60 days, regardless of the balance amount.
8. If the balance is outstanding for more than 90 days, this office may proceed with outside collection activity. The responsible party agrees to pay related collection fees and/or court costs associated with collection the debt.
9. The responsible party is aware that they are responsible for keeping all contact information up to date with the office. Non- receipt of a balance due notification does not absolve the responsible part of the obligation to resolve such bill.

Signature _____ Date _____
Patient Name _____ Relationship to Patient _____

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PLEASE READ THE FOLLOWING

This consent is a condition of your treatment, by us. If you decide not to sign this consent we may decline to treat you. **Privacy Practice Notice: You have the right to read our Privacy Practice Notices before you decide whether to sign this consent**. You may ask the receptionist for a copy. Our notice provides a description of our treatment, payment activities and health care operations and of the uses and disclosures we may make of your protected health information. By signing this form, you will consent to our use of your dental care records, to carry out treatment, payment activities and health care operations as set forth in our Privacy Practices Notice. **Right to Revoke: This consent is effective until revoked by you. We may decline to treat you or to continue treating you/ your children, if you revoke this consent.**

*****Under 18 Parent signature: If this consent is signed by a personal representative and/or parent on behalf of the individual, please sign******

Childs Name: _____Signature: _____,
Relationship to Patient: _____.

I give permission for the following people to bring my child/children for dental care and treatment and to receive information relating to my child (s) care. ***I understand that if anyone else brings my child/children I well send updated medical history with them. If there is no change since last visit, I will note that information.

Signature of Parent: _____Date: _____

This consent applies to: (grandparent, aunt, uncle, sibling, etc.)

Name: _____ Relationship to my child: _____
Name: _____ Relationship to my child: _____
Name: _____ Relationship to my child: _____

I acknowledge that if anyone other than the above named people were to bring my child/children, I must fax, or mail my written permission ahead of the appointment along with current medical history.

For office use only: _____ Individual refused to sign due to: _____