Welcome To

About Your child

Child's Name: _____
LAST FIRST M.I.

Nickname: _____ Age _____

Today's Date: ____/____/____ Boy ☐

Birth date: ____/____/____ Girl ☐

Child's Address: _____
STREET/APT #

_____
CITY STATE ZIP

How did you hear about us?

_____

Dental Insurance Information

If Tenn Care, circle plan: Tenn Care Select
Blue Care • Amerigroup • United Healthcare • Cover Kids

Child's SSN: _____

Primary Dental Insurance Company's
Name: _____
Address: _____
STREET

_____
CITY STATE ZIP

Group #: _____ ID #: _____
Ins Co. Phone #:(____)_____
Policy Holder: _____
SSN: _____ DOB:___/___/___
Insured's Employer: _____
Employer Phone #: (____)_____

Secondary Dental Insurance Company's
Name: _____
Address: _____
STREET

_____
CITY STATE ZIP

Group #: _____ ID #: _____
Ins Co. Phone #:(____)_____
Policy Holder: _____
SSN: _____ DOB:___/___/___
Insured's Employer: _____
Employer Phone #: (____)_____

Child's Family Information

Who is accompanying this child today?

☐Mom ☐ Dad ☐ Other _____

Do you have *legal custody* of this child? Yes ☐ No ☐

Mom's Name: _____
Circle If: STEP MOTHER GUARDIAN

Address: _____
STREET/APT # CITY STATE ZIP

(____)_____ (____)_____
HOME PHONE # WORK PHONE #

(____)_____ (____)_____
CELL PHONE # OTHER PHONE #

Birth Date: ____/____/____ SSN: _____

Driver's License: _____

Dad's Name: _____
Circle If: STEP FATHER GUARDIAN

Address: _____
STREET/APT # CITY STATE ZIP

(____)_____ (____)_____
HOME PHONE # WORK PHONE #

(____)_____ (____)_____
CELL PHONE # OTHER PHONE #

Birth Date: ____/____/____ SSN: _____

Driver's License: _____

Would you like to have 24 hour access to your account information, appointment times, and emailed appointment reminders?

Email address: _____

Person financially responsible: _____

(____)_____ (____)_____
HOME PHONE # OTHER PHONE #

Consent for Treatment/Payment

The information I have given is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. I understand 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 authorize the dental staff to perform the necessary dental services to ny minor/child.

_____
Signature of Parent/Guardian

_____
Date

I certify that the patient is covered by **insurance** with _____ and assign directly to Dr. Rowland or associated staff dentists. I understand that if I have dental insurance coverage that my claim will be submitted to my carrier as a courtesy by the Children's Dental Center. I also understand that I am responsible for any co-pays, deductibles or percentages that my insurance policy does not cover. I further understand that should it become necessary for Children's Dental Center to seek assistance in the collection of my outstanding bill, that I will be held responsible for any collection agency fee, court cost and/or attorney fees that may be incurred as a result. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Signature of Parent/Guardian

_____
Date

Child's Current Dental Information

Child's Name: _____

Does your child have a cavity now? **Y N**

Do other family members get a lot of cavities? **Y N**

Has your child had cavities in the past? **Y N**

Are there any current dental concerns that you need to discuss with the doctor? ____

_____

_____

_____

ORAL CARE HISTORY (*circle Yes or No*)

Has your child had dental fillings before? **Y N**

Was the treatment (*circle*): easy difficult

Was some form of sedation used? **Y N**

If yes, please circle what was used:

Nitrous Oxide Demerol Valium

General Anesthesia Other: _____

Has your child had any oral surgery? **Y N**

If yes, please describe the injury _____

_____

_____

Has your child had any of the following? (*circle*)

Abscess (gum boil) Canker Sore Toothache

Bad Breath Fever Blister (cold sore)

HABITS (*check ALL that apply*)

☐ Sucks (*circle ALL that apply*):

Thumb Finger Pacifier Other Objects _____

☐ Grinds teeth at night

☐ Breaths through mouth most of the time

☐ Has chronic irritation around the mouth

Has your child seen an orthodontist?

If yes, when: _____/_____/_____

Who: _____

Were there any suggestions? _____

_____

DIET & NUTRITION

What beverage(s) does your child most often drink? (*circle ALL that apply*):

Milk Juice Soda Water Punch Kool-aid

Other: _____

What snacks does your child most often eat? (*circle ALL that apply*):

Candy Chips Cookies Fruit Roll-ups Raw Vegetables Cheese

Other: _____

ORAL CARE

How often does your child brush? _____

How often does your child floss? _____

FOR STAFF USE ONLY

Caries? _____

Existing restorations? _____

Frankel? _____

Crossbite? _____

Grooves? _____

Hygiene? _____

Other Issues? _____

_____

_____

Child's Current Medical History

Child's Physician: _____

City/State _____ Phone _____

Last Medical Exam ___/___/___ Is child seeing physician for medical conditions now? **Y N**

Ever been hospitalized? **Y N** Why/Where/When _____

_____

_____

Receiving any medications or drugs? **Y N** Names: _____

_____

_____

Is Child allergic to: ☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Fish ☐Metal ☐Food Dyes ☐Local Anesthetics ☐Latex ☐Antibiotics ☐Pain Medication ☐Other _____

Has child had any history of or difficulty with any of the following?
(*CIRCLE & DATE all that apply*)

AIDS/HIV	Chicken Pox	Hearing Problems	Rheumatic fever
ADHD	Congenital Heart	Heart Problems	Active Sickle Cell
ADD	Convulsion	Heart Murmur	Sickle Cell Trait
Autism	Developmental Delay	High Blood Pressure	Sinus Problems
Anemia	Diabetes	Kidney Problems	Speech Problems
Asthma	Down Syndrome	Leukemia	Thyroid Disease
Bladder Problems	Drug/Alcohol Abuse	Liver Disease	Tuberculosis
Blood Disorder	Epilepsy/Seizures	Measles	
Cancer	Frequent Headaches	Mononucleosis	
Cerebral Palsy	Fainting	Mumps	

Has child ever had any serious illness not listed above *(including pregnancy)*?

_____

_____

_____

In the event of an emergency, whom should we contact *(OTHER THAN PARENT)*?

Name _____

Relationship _____ Phone _____

Acknowledgment of Receipt of Notice of Privacy Practices

* You may refuse to sign this acknowledgement *

I, _____ (Child's name), have received a copy of this office's Notice of Privacy Practices.

Please Print Guardian's name: _____

Signature of Parent/Guardian: _____ Date: _____

For Office Use Only

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

___ Individual refusal to sign

___ Communications barriers prohibited obtaining the acknowledgement

___ An emergency situation prevented us from obtaining acknowledgement

___ Other (Please Specify):

3394 S. Houston Levee Rd.
Germantown, TN 38139

5226 Airline Rd., Ste 125
Arlington, TN 38002

1684 Poplar Ave.
Memphis, TN 38104

Permission Letter

Patient Name(s): _____

If someone other than the parent or legal guardian may bring your child (ren), please list their name(s) below. They must be 18 years of age and have a photo i.d. We **are not** able to see your child in the absence of a parent/guardian unless the following is filled out. This letter gives permission to Children's Dental Center to complete an exam, cleaning, fluoride, x-rays and dental treatment with the named party. Any fees due will need to be brought to the appointment with the person bringing your child. We expect them to remain in our office with your child. Please do not drop your child off or schedule other errands during their appointments.

Name of person bringing patient	**Relationship to patient**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Parent/Guardian Signature Date

3394 S. Houston Levee Rd.
Germantown, TN 38139

5226 Airline Rd., Ste 125
Arlington, TN 38002

1684 Poplar Ave.
Memphis, TN 38104

FINANCIAL AGREEMENT

I understand that I am responsible for any co-pays, deductibles or percentages that my insurance policy does not cover at the time of the visit. The parent who brings the child is the responsible party and will pay at checkout. We do not do second party billing.

I also understand that if I have a dental insurance plan Children's Dental Center will submit my dental claim to my carrier as a courtesy.

I am aware that most dental insurance plans DO NOT COVER 100%.
Plans vary from company to company.

We will give you an estimated treatment plan prior to the appointment. We do not know all of the limitations and downgrades that each plan may have. However, parents must understand: We are only estimating insurance benefits; you are responsible for payment of any amounts the insurance does not cover, for whatever the reason.

For your convenience, we do accept *Cash, Check, Visa, Master Card, Discover* and *Care Credit*.

Should it become necessary for Children's Dental Center to seek assistance in the collection of my outstanding bill, I will be held responsible for any collection agency fees, court cost and/or attorney fees that may be incurred as a result. The collection fee of 33.3% will be added to your bill before it is sent to collections.

Patient name: _____

Signature: _____ Date: _____

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Memphis, TN 38104

CANCELLATION POLICY

Patient's name (s): _____

We appreciate that you and your family come to our office. We work hard to provide your child with the best dental treatment available.

To ensure that each child receives the appropriate treatment, it is important that our office have current telephone numbers and addresses at all times. It is necessary that we confirm all appointments with a patient who brings his father. Our office calls 1 to 2 days before to confirm. In case we can not contact you due to invalid telephone numbers, we reserve the right to cancel your appointment.

Emails are sent as reminders only and may not reflect the correct time of your appointment. All appointments must be confirmed by calling the office to receive your exact time.

Please notify our office 24 hours in advance of the cancellation of all dental treatment appointments and cleanings.
We require a 3 day cancellation notice for all sedation appointments and all hospital cases must be confirmed 7 days in advance. You can leave a message at (901) 861-9668) 24 hours. one day.

If you miss an appointment without notifying our office, we reserve the right to charge a lost appointment fee of $ 50.00 or dismiss the family. All fees must be paid to reschedule another appointment.

Please limit the family members who accompany your child to you and another person, if possible. Thanks for your cooperation.

Parent/Guardian Signature Date