TEETERS

Pediatric Dentistry

We are so pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health!

PATIENT INFORMATION

Child's Name: _____
Last First Middle Nickname

❑ Male ❑ Female Age: _____ Date of Birth: ____/____/____ Hobbies: _____

Address: _____
Street Apt.# City State Zip

Home Phone #: _____ Mom's Cell #: _____ Dad's Cell #: _____

Email Address: _____

How would you prefer us to contact you for confirming your child's appointment? _____

Whom may we thank for referring you: ❑ Individual _____

❑ Yellow Pages ❑ Website ❑ Insurance Website ❑ Other Marketing _____

Does patient (child) have their own insurance coverage? ❑ Yes ❑ No

If yes, please complete the following:

Child's ID#: _____ When did coverage begin: _____

Coverage provided by: ❑ CMDP ❑ ACHCCS ❑ IHS ❑ _____
Provider Name

PARENT'S INFORMATION

❑ Father ❑ Stepfather ❑ Guardian

Name: _____

Address (if different than above):

_____

Home # (if different than above): _____

Work # _____ Ext: _____

Employer: _____ Occupation: _____

Social Security #: _____

Date of Birth: _____ / _____/ _____

Insurance Co: _____

Phone #: _____

Claims Address: _____

Group #: _____ ID #: _____

Member Name (Policy Holder): _____

Do you have dual insurance? ❑ Yes ❑ No

If yes, with whom? _____

❑ Mother ❑ Stepmother ❑ Guardian

Name: _____

Address (if different than above):

_____

Home # (if different than above): _____

Work # _____ Ext: _____

Employer: _____ Occupation: _____

Social Security #: _____

Date of Birth: _____ / _____/ _____

Insurance Co: _____

Phone #: _____

Claims Address: _____

Group #: _____ ID #: _____

Member Name (Policy Holder): _____

Do you have dual insurance? ❑ Yes ❑ No

If yes, with whom? _____

PATIENT INFORMATION

Date of last Dental Visit: ___/ ___/ ___ Last Cleaning/Fluoride:___ /___ /___ Last X-Rays:___ /___ /___

Dentist Name_____ Phone Number_____

My child brushes his/her teeth ____ (#) of times during the day.
Do you ever help your child brush his/her teeth? (Please circle) Always Sometimes Never

Does your child floss every day? ❑ Yes ❑ No Is fluoride taken in any form? ❑ Yes ❑ No

Any unhappy dental experiences? ❑ Yes ❑ No Any injuries to the mouth/teeth/head? ❑ Yes ❑ No

Has your child complained about dental problems? ❑ Yes ❑ No

Does you child have any mouth habits? (please circle one or more) Thumb sucking Nail Biting Mouth Breathing Pacifier Sleeping with bottle Other:_____

MEDICAL HISTORY

Child's Physician:_____ City/State:_____ Phone #:_____

Date of last physical exam:___/___ /___ Current Medical Conditions:_____

Does your child have a heart murmur? ❑ Yes ❑ No If so, is pre-medication required?_____

Cardiologist Name_____ Phone Number_____

Is your child taking medication? ❑ Yes ❑ No Please list:_____

Has he/she been hospitalized? ❑ Yes ❑ No If so, why?_____

Has he/she had surgery? ❑ Yes ❑ No Please list:_____

Any impairments/disabilities? ❑ Yes ❑ No Please list:_____

Drug or food allergies? ❑ Yes ❑ No If yes, please list:_____

_____

HAS YOUR CHILD HAD ANY HISTORY OF THE FOLLOWING: IF YES, PLEASE CIRCLE.

ADD/ADHD	Cerebral Palsy	Hearing Impairment	Mumps
AIDS/HIV	Chicken Pox	Heart Murmur	Rheumatic Fever
Anemia	Congenital Heart Disease	Hepatitis	Scarlet Fever
Asthma	Convulsions/Seizures	Hemophilia	Sickle Cell Disease
Artificial Heart Valve	Diabetes	Kidney/Liver Disease	Sinus Problems
Autism	Drug/Alcohol Abuse	Learning Disabilities	Thyroid Disease
Bladder Problems	Epilepsy	Measles	Tuberculosis
Bleeding Problems	Fainting	Mental Problems	Other:_____
Cancer/Tumors	Headaches	Mononucleosis	_____

Girls: Are you pregnant? ❑ Yes ❑ No Taking Birth Control Pills? ❑ Yes ❑ No Nursing ❑ Yes ❑ No

CONSENT FOR TREATMENT

The information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Teeters and/or associates to perform the necessary dental procedures including, but not limited to, the use of Nitrous Oxide (laughing gas), Local Anesthetic (like Lidocaine), and any necessary x-rays needed on my child.

ALL PROCEDURES WILL BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.

Parent/Guardian:_____ Date:_____

This office follows all current HIPPA procedures and guidelines to protect your health information. A copy of the full article is available for you at the front desk if needed. By completing and signing this form you grant this office the authorization to use your protected health information in a manner consistent with current guidelines. INTL:_____

CONSENT FOR TREATMENT

- Our policy requires payment in full at the time of service. Insurance reimbursement for covered services is subject to maximum allowable fees, deductibles, and co-payments. Your responsibility is estimated and due at the time of treatment. It is also your responsibility as parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected.
- If your account is not paid within 90 days, you will be liable for all collection fees, legal and court fees, interest charges, and any other expenses incurred while collecting your account.
- I hereby authorize all insurance benefits, if any, to be assigned directly to Karen A. Teeters, D.D.S., otherwise payable to me for services rendered. I authorize the release of any information required to process insurance claims, including the use of my signature on all insurance submissions.

Parent/Guardian:_____ Date:_____

OTHER OFFICE POLICIES

- If you are unable to keep an appointment, please notify our office within 24 hours. We are dedicated to providing our patients with timely scheduling. Please do not skip appointments or avoid calling to reschedule if needed. This will help ensure other deserving patients may be able to be scheduled in your original appointment time.
- There may be a $50 fee charged to your account for all appointments that are cancelled and/or broken within less than 24 hours.
- After having 3 missed or broken appointments, we will no longer be able to provide your child with dental care. If this happens, you will be notified by mail of your child's dismissal from our practice. We will continue to provide emergency dental care for your child for up to 30 days following the dismissal.
- We will be unable to reschedule your child's first new patient visit if you do not show up for that visit or do not notify us of the cancellation within 24 hours prior to that visit.

Parent/Guardian:_____ Date:_____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name:_____ Relationship:_____ Phone #:_____

Name:_____ Relationship:_____ Phone #:_____

UPDATE

SIGNED (Parent or Guardian)	Date	DENTIST	Date