Welcome

Welcome to Children's Dentistry of Murfreesboro! Our primary goal is to make every visit fun & educational. Our practice is based on preventative dental care. We strive to teach good oral care that will enable your child to maintain a beautiful smile for a lifetime! In order to provide the safest comprehensive dental care available, we ask that you complete this detailed medical form prior to your scheduled appointment. Please feel free to ask questions about any items that you are not familiar with. Thank you!

About Your Family Today's Date___________________

Child's Name____ Preferred Name________________________

Date of Birth___________________ SS# ___________________________ ☐ Male ☐ Female

Patient Lives With: ☐Mother ☐ Father ☐ Other:______________________________

Email Address:__________________________________

☐ Mother's information ☐ Step-mother ☐ Legal Guardian ☐ Grandmother ☐ Responsible for account

Name:		DOB:	Occupation:
Address:		SS#	Employer:
City, State, Zip:			Work phone:
Home phone:	Cell phone:		Marital Status:

☐ Father's information ☐ Step-father ☐ Legal Guardian ☐ Grandfather ☐ Responsible for account

Name:		DOB:	Occupation:
Address:		SS#	Employer:
City, State, Zip:			Work phone:
Home phone:	Cell phone:		Marital Status:

May we leave a message regarding your child's dental appointments and care with:

☐ home phone ☐ work phone ☐ cell phone ☐ answering machine ☐ anyone answering my home phone

Dental Insurance Information

Ins. Co. Name ____ Phone ____________________________

Group # _______________________ Local # ____________________ Policy # _________________________

Who is the primary person on this policy? __________________________ SS# _________________________

Do you have secondary insurance? Yes ☐ No ☐

Ins. Co. Name ____ Phone _____________________________

Group # _______________________ Local # ____________________ Policy # ________________________

Who is the primary person on this policy? __________________________ SS# _________________________

Emergency Information

Patient Name ____

In the case of an emergency where neither parent nor legal guardian can be reached, please identify the following information for the next closest relative not living with the patient.

Name ____ Relation _____________________________
Phone ______________________________ Address ____

How did you hear about our office?

□ friend __________________
□ drive-by
□ newspaper advertisement
□ Google.com or other search engine
□ Yellow Book
□ Doctor's referral __________________
□ insurance referral
□ other ____________________________

Medical/Dental Release Statement
I give my consent for Dr. Jack Mallette of Children's Dentistry of Murfreesboro to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Children's Dentistry of Murfreesboro of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant Dr. Mallette and his staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

_____________ Initial

Requirement for Filing Insurance Claims:
I hereby authorize payment of insurance benefits directly to Children's Dentistry of Murfreesboro. I understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 30-days of treatment. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection &/or legal fees incurred in an attempt to collect on this amount. _____________ Initial

____ _________________________
Signature of Parent or Legal Guardian Date

Medical History

Patient Name ____

Please check yes or no if any of the following medical conditions apply to your child.

Y ☐ N ☐ Sickle cell Anemia or trait (If yes, when ________)
Y ☐ N ☐ Bleeding Disorder or Hemophilia (If yes, when?_______)
Y ☐ N ☐ Blood Transfusion (Date_________) (Right, Left, Both)
Y ☐ N ☐ Blood Pressure Disorder
Y ☐ N ☐ Anemia
Y ☐ N ☐ Heart Condition ___________________
Y ☐ N ☐ Heart Murmur (innocent or pathological)
Y ☐ N ☐ Tetralogy of Fallot
Y ☐ N ☐ Rheumatic Fever or Scarlet Fever
Y ☐ N ☐ Hepatitis or Jaundice (If yes, when ______________)
Y ☐ N ☐ Asthma or lung problems
Y ☐ N ☐ Pneumonia (If yes, when ________)
Y ☐ N ☐ Diabetes (NIDDM or IDDM _______ x day)
Y ☐ N ☐ Seizures, Epilepsy or convulsions
Y ☐ N ☐ Cancer, Malignancy, Leukemia, or Lymphoma
Y ☐ N ☐ Use of tobacco products
Y ☐ N ☐ Drug or Alcohol Abuse __________
Y ☐ N ☐ Emotional or Behavioral problems
Y ☐ N ☐ Diagnosed with ADD, ADHD, or Hyperactivity
Y ☐ N ☐ Handicaps or Disabilities ______________________
Y ☐ N ☐ Seasonal allergies, hay fever, etc…
Y ☐ N ☐ Autistic Spectrum Disorder
Y ☐ N ☐ Latex Allergy or Sensitivity
Y ☐ N ☐ Delayed Development (Approx age child functions ___________)

Y ☐ N ☐ Measles, Mumps, or Chicken Pox
Y ☐ N ☐ Tonsillectomy &/or Adenoidectomy
Y ☐ N ☐ Eye problems (Right, Left, Both)
Y ☐ N ☐ Glaucoma (Right, Left, Both)
Y ☐ N ☐ Hearing Impairment (Right, Left, Both)
Y ☐ N ☐ Sexually Transmitted Disease
Y ☐ N ☐ Immunologic Disorder HIV, AIDS, or ARC
Y ☐ N ☐ Kidney Disease or transplant
Y ☐ N ☐ Liver Disease or transplant
Y ☐ N ☐ Bruises or Bleeds easily
Y ☐ N ☐ Stomach/GI Disorder
Y ☐ N ☐ Thyroid Disorder
Y ☐ N ☐ Currently pregnant
Y ☐ N ☐ Implanted shunts, pins, screws, or rods
Y ☐ N ☐ Fainting spells
Y ☐ N ☐ Physical or Emotional Abuse
Y ☐ N ☐ Ear Infection(s)/Otitis Media
Y ☐ N ☐ Cleft lip/palate
Y ☐ N ☐ Learning Disability
Y ☐ N ☐ Psychiatric problems
Y ☐ N ☐ Congenital Birth Defects/Syndrome
Y ☐ N ☐ Tuberculosis or Previous Positive Test
Y ☐ N ☐ Any stays in Hospital? ____________

Signature of Parent or Legal Guardian __________________________________

Doctor's Signature____

Patient Name ____

Has the patient had the DPT immunization series for diphtheria, polio & tetanus? Yes ☐ No ☐

Is the patient currently taking any medication(s)? Yes ☐ No ☐
If yes, please list: ____

Is the patient currently under the care of a physician? Yes ☐ No ☐
If yes, for what? ____

Is your child allergic or has your child ever had an adverse reaction to a specific medication? Yes ☐ No ☐
If yes, please list the medication(s): ____

Please list the names & phone numbers of any treating physicians.

Physician's Name	Type of Physician	Office Phone #

When was your child's last check-up at his/her physician? ____

Dental History

Please check yes or no if any of the following medical conditions apply to your child.

Y ☐ N ☐ Bad breath / Halitosis
Y ☐ N ☐ Bleeding Gums
Y ☐ N ☐ Stained or discolored teeth
Y ☐ N ☐ Cold sores or Fever blisters
Y ☐ N ☐ Dry mouth
Y ☐ N ☐ Popping/soreness of jaws (Right, Left, Both)
Y ☐ N ☐ Dental infection or Abscess
Y ☐ N ☐ Pain from teeth
Y ☐ N ☐ Missing or extra teeth
Y ☐ N ☐ Injury/trauma to teeth, mouth, or face

Has your child expressed any dental anxiety or fear? Yes ☐ No ☐

Has your child had any previous bad experiences at a dental office? Yes ☐ No ☐

Does your child receive fluoride supplementation? Yes ☐ No ☐

Does your child brush his/her teeth daily? Yes ☐ No ☐ If yes, do you assist? Yes ☐ No ☐

Does your child suck a thumb, finger, or pacifier? Yes ☐ No ☐

How would you predict your child's behavior to be? ☐ cooperative ☐ fearful ☐ defiant ☐ don't know

How would you describe your child's current oral health? ☐ excellent ☐ good ☐ fair ☐ poor
What are your primary concerns about your child's oral health?

____

____

Financial Policy

We appreciate you choosing our office for your child's dental care. At Children's Dentistry of Murfreesboro, we value our relationship with your family and would like to offer the following as our payment policy.

- We understand that the patient may reside with one parent and be financially supported by a parent outside the household. However, in all cases we will ultimately seek payment from the custodial parent/guardian presenting the child for treatment.

- Insurance – This relationship is between the insured and the insurance carrier. We cannot compel payment or alter your coverage. We are happy to assist you by filing your claim and providing any needed information to your carrier; however, you are responsible for all unpaid balances. In the event of duplicate payments, your account will be reimbursed.

- We will try to **estimate** your portion of the bill. After your insurance carrier remits payment you will receive a statement if you have an outstanding balance. A finance charge may be added to your account on any balance not paid in full within 30 days from date of the statement.

- Once the treatment plan and estimated insurance benefits are reviewed with you, we require that you pay your portion (unmet deductible, co-payment, etc.)in full at the time of service.

- For your convenience we accept cash, check, VISA, Discover, MasterCard, and American Express. We also have special dental financing plans available through our third party financing company.

- When impressions are taken for an appliance, half of the fee is due when the appliance is ordered and the remaining balance paid in full when the appliance is delivered.

- Please note that parents or guardians bringing the child into the office on the day of the service *will* be expected to pay for services rendered. Only if payment arrangements have been made will we see the child for treatment.

- Any appointment cancellations or changes should be made at least 24 hours in advance. A fee of $25.00 may be imposed for a broken appointment. Repeated missed appointments may result in dismissal from the practice.

- A fee of $35.00 will be assessed for any returned checks. Any unpaid balances over 30 days will be assessed a finance charge of 1.5% per month / 18.0% annual percentage rate. Any balances left unpaid and sent to collections, will be assessed a collection account fee of 35% of the unpaid balance.

I have read and understand the payment policies for Children's Dentistry of Murfreesboro.

______________________________	______________________________	______________
Parent/Guardian Printed Name	Parent/Guardian Signature	Date

Parental Guidelines

We want you and your child to receive the best possible treatment at our office while having **fun!!!** We feel this is a joint process in which the parents will play a pivotal role.

Our dental treatment area serves multiple purposes. We would like to clarify the function of the treatment area and how you can maximize the outcome for your child. Children's Dentistry of Murfreesboro performs both non-invasive and invasive procedures simultaneously in the treatment area. Your child's regular check-ups are considered non-invasive, while fillings and other dental procedures are considered invasive.

The dentist requires the same level of concentration as any other physician. Minimum movement, conversation, and distractions in and about the operative area are crucial for optimal care of the children. We appreciate your cooperation as it is **alway**s our main focus to insure your child is receiving the best possible care.

You may choose whether or not to accompany your child to his/her filling or hygiene appointment. Although we have seen that **most** children's behavior is improved without parents present, we are open to having you present with your child. If you wish to be present, we suggest the following **guidelines** to improve chances of a positive outcome:

You can assist us by following a few guidelines:

- Always remain positive to build the child's confidence and reduce fears. Please avoid telling your child they are getting a "shot", a "tooth pulled", or that it may "hurt".
- Please maintain minimal conversation with your child during procedures. Support your child with touches instead. This allows us to maintain direct communication with your child.
    - Children often listen to their parents instead of us and may not hear our guidance intended to help them get through the appointment easily.
- We may ask you to leave the treatment area momentarily in an attempt to improve behavior.
    - We will continue to support your child at all times and will not resort to rough or harsh tactics. If at any time you feel uncomfortable, **please,** let us know.

Additional siblings, over the age of two in the treatment room, may misunderstand what the dentist is doing. This could cause anxiety and fear in the future. We recommend not having other siblings present for filling appointments. Following these few simple guidelines will help us insure the best possible results for your child. Again, thank you for your support and cooperation.

______________ Initial