Welcome

Courtney L. Wilson, DDS

3285 Hacks Cross Road, Suite 101
Memphis, TN 38125
Phone: 901 759-0970 FAX: 901 759-0904

Health History Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate _____/_____/_____ Child's Age _____

School_____Grade_____

Child's Home # (_____)_____

SS#_____

Child's Home Address:_____

_____
City State Zip

Email Address:_____

2. Who may we thank for referring you to our office?

_____

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepfather Guardian Birthdate _____/_____/_____

Employer _____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship_____

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

6. Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

_____
City State Zip

Home # (_____)_____

Work # (_____)_____

Cellular # (_____)_____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

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

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

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

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

9. 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?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

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

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

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

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking_____

_____

Please list all allergies_____

_____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good **Fair** **Poor**

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

11.

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 authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

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

Initials _____ Date _____

Doctor's Comments _____

_____

_____

_____

All About Kids Pediatric Dentistry
3285 Hacks Cross Rd, Ste 101, Memphis, TN 38125
Phone 901-759-0970 Fax 901-759-0904
Allaboutkidsteeth.org

APPOINTMENT CANCELATION 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 24 hours 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:

_____ If you are late for your appointment, it may be necessary for you to be reschedule and that appointment will be considered a cancellation with out adequate notice.

_____ a $25.00 fee may be accessed to your account and must be paid before being rescheduled.

_____ Patient may be placed on “Same Day Scheduling Restriction”, meaning the patients may call and request an appointment for the “same day”only, no advance scheduling will be available.

_____ 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. If you have any questions about these policies, please feel free to ask our front desk staff for assistance.

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. When ever 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.

_____ 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.

Patient Name _____Date _____

Signature _____Relationship to Patient _____

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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, and MC.
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 and we will provide you with a claim form to file for your reimbursement from the insurance company.
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 your primary insurance claim as a courtesy to you and 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 co payments 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.

Patient Name _____ Date _____

Signature _____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.)
_____ Relationship to my child _____
_____ Relationship to my child _____
_____ 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.

****

May we leave a detailed message concerning your child's care or appointment on your answering machine? YES _____ NO _____

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

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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

YOU CAN FIND THE LINK TO OUR FACEBOOK PAGE BY SCANNING THE BARCODE BELOW

I refuse authorization _____

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 <u>do not</u> 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

_____

Patient's name