Patient Information Form

Patient's Full Name_____*Called*_____

Birth Date _____Sex: ☐ M ☐ F School the child attends_____

How did you hear about us? _____

Orthodontist _____Siblings Treated Here (if any) _____

Parent/Legal Guardian Information

Mother's Full Name (*if different from patient*)_____D.O.B._____

Street Address _____

City_____ State_____ Zip_____ Home #_____

Employer_____ Work #_____**Cell#**_____

Father's Full Name_____ D.O.B._____

Street Address (*if different from patient*)_____

City_____ State_____ Zip_____ Home #_____

Employer_____ Work #_____Cell#_____

Email Addresses: _____

We are delighted you have chosen our office for your child's dental care. We have implemented the following office and financial policies to better serve you and your child. Please read them carefully, and let us know if you have any questions or concerns.

OFFICE POLICIES

We allow only one parent in the examination room with your child. Siblings or other family members will be asked to remain in the reception room. This will help us provide the safest and most effective dental care for your child.

Any patient that has not been seen in our office within a Three-year span will become inactive and if seen again, will be considered a new patient. Our established recall patients will be seen until the ages of 19, with some exceptions for special needs patients.

If you have to cancel or reschedule an appointment, we request that you call our office **at least 48 hours prior** to the scheduled appointment time. This will enable us to contact other patients on our waiting list, some of whom are **in pain** and could take advantage of your appointment time if proper notification is given by you. A broken appointment charge of $25.00 will be made for failure to keep an appointment unless we are contacted **at least 24 hours in advance.**

If an emergency arises and you cannot keep your scheduled appointment, we ask your courtesy in notifying us **immediately**.

We continually strive to stay on schedule and see your child at his/her appointed time. In order to do this, we ask patients arriving **more than 15 minutes** late to reschedule their appointment unless the next appointment time slot is available.

Any child that has missed 3 consecutive appointments without proper notification will be dismissed from the practice.

I hereby authorize payment directly to the attending dentist for the group insurance benefits otherwise payable to me. I authorize the dentist to release any information acquired in the course of treatment or examination. I understand that responsibility for payment for dental services provided in the office for my dependents is mine, due and payable at the time services are rendered. I further understand that a 1.5% finance charge or a $5.00 billing fee (whichever is greater) will be added to any balance over 60 days. In the event of default, I understand there will be a 30% collection cost and reasonable attorney fees required to effect collection of the note. Please check with the front business office regarding which insurances Volunteer Pediatric Dentistry is in network with as well as what forms of payment are accepted or if this policy has changed.

Signature of Parent or Legal Guardian_____

Please Print Name _____ **Date** _____

VOLUNTEER PEDIATRIC DENTISTRY

Child's Name _____ Date of Birth_____ Sex M F

DENTAL

Y N Is this your child's first dental visit? If no, when was the last visit and by whom?_____

Y N When does your child brush his/her teeth? ☐ Morning ☐ Between Meals ☐ Bedtime

Y N Do you or someone supervise the brushing?_____

Y N Does your child floss? _____

What type of water do you use? ☐ City ☐ Well ☐ Bottled

Y N Does your child currently use a bottle or breast feed? If no, at what age did the child stop? _____months

Y N Does your child usually have a sippy cup between meals?

Does your child consume any of the following on a daily basis? (check all that apply)
☐ Soda ☐ Juice ☐ Chips ☐ Crackers/Dry Cereal ☐ Candy/Gum

Y N Does your child suck a thumb or finger, use a pacifer, chew on fingernails or other materials?

Are there any specific dental concerns you would like us to address?_____

MEDICAL

Please answer every question

Y N Does your child have a Doctor (Pediatrician)? Name: _____

Phone:_____

Y N Are your child's vaccinations current?

Y N **Does your child take a medication?**

Y N **Does your child have any allergies to medication, food, latex or other materials?**

Y N Has your child ever been admitted to a hospital, had surgery or a serious illness or injury?

Does your child have a history of any of the following (circle all that apply):

Y	N	Heart Murmur	Y	N	Bleeding Disorders
Y	N	Heart Disease	Y	N	Anemia
Y	N	Asthma	Y	N	Transfusions
Y	N	Reactive Airway Disease	Y	N	HIV
Y	N	Tuberculosis	Y	N	Immuno-compromised Conditions
Y	N	Epilepsy	Y	N	Diabetes
Y	N	Seizures	Y	N	Lupus
Y	N	Cerebral Palsy	Y	N	Arthritis
Y	N	Convulsions	Y	N	Autoimmune Diseases
Y	N	Shunts	Y	N	Premature Birth
Y	N	Sight Concerns	Y	N	Liver Disease (hepititis, jaundice, etc)
Y	N	Hearing Concerns	Y	N	Kidney Concerns (Stones)
Y	N	Speech Concerns	Y	N	Stomach/GI Concerns
Y	N	Cancer (Leukemia, Tumors)	Y	N	Skin/Bone/Muscle Disorders
Y	N	Attention Disorders (ADD, ADHD, etc)	Y	N	Snoring
Y	N	Sensory Disorders (Autisum Spectrum)			

Y N Any other conditions we should be made aware of: _____

If you anwered Yes to any of the above questions, please explain: _____

_____

_____

_____

_____ _____ _____

Guardian Signature Date Relationship to Child

AUTHORIZATION FOR RELEASE OF INORMATION

Name of Patient _____ Date of Birth _____

VOLUNTEER PEDIATRIC DENTISTRY is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions. Description of information to be released could be, but not limited to the following: Appointment times, Billing Information, Insurance Information, Treatment Plans, Medical Information, School Excuses, K-12 Release Information.

Mode to Receive Information (Approve each mode that you authorize to receive information)

Y / N CELL PHONE (and text)

Y /N VOICEMAIL

Y /N EMAIL

Y /N POSTAL MAIL

Entity to Receive Information (Approve each person/entity that you authorize to receive information)

Y / N CHILDS'S SCHOOL Name of School: _____

Y / N PARENT (MOTHER)

Y / N PARENT (FATHER)

Y / N LEGAL GUARDIAN OR OTHER (ex. Grandparent) Name:_____

Y / N PEDIATRICIAN Name of Doctor: _____

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending a written notification to Volunteer Pediatric Dentistry.

I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY CHILD'S HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

I HAVE ACKNOWLEDGED THAT I HAVE RECEIVED A COPY OR WAS ABLE TO READ A COPY OF THE VOLUNTEER PEDIATRIC DENTISTRY'S NOTICE OF PRIVACY PRACTICES IF REQUESTED.

_____ Date: _____

Signature of Parent, Legal Guardian, or Personal Representative

Relationship to Patient _____ Printed Name _____

TREATMENT OF MINOR CHILDREN
Parent/Legal Guardian Consent for Dental Treatment

Volunteer Pediatric Dentistry

1516 Coleman Road Suite 201
Knoxville, TN 37909

209 East Emory Road Suite 101
Powell, TN 37849

865-558-8857 (Phone)
865-558-0291 (Fax)

Contact Person: Michael Koch

_____ _____
Child's Name Date of Birth

I authorize the above child is legally under my care and I am able to make medical/dental decisions for him/her.

_____ _____ _____
Parent/Legal Guardian Contact (Print) Signature Date

Parental contact information for questions regarding treatment of the child:

Contact info: (Primary Phone) _____ (Secondary Phone) _____

(Email Address) _____

I give my authorization for all dental treatment, for the above named child, which may be required with or without my presence. I agree to pay for all services rendered to my child. This may include, but not limited to prophy (cleanings), fluoride treatments, diagnostic radiographs, examination, composite fillings, sealants and extractions. If additional treatment is needed, Volunteer Pediatric Dentistry has my permission to perform that treatment regardless of my presence in the office with consent from the guardian bringing in my child.

In the event of an emergency, Volunteer Pediatric Dentistry and staff have my permission to take any and all necessary steps to ensure the safety and well-being of my child.

I understand and agree to Volunteer Pediatric Dentistry's Treatment of Minor Consent Form and its terms. This authorization will remain in effect until I revoke this authorization in writing and submit it to Volunteer Pediatric Dentistry prior to this date.

Printed Name of Guardian: _____
Signature of Guardian: _____ Date _____
Relationship to Patient: _____

Volunteer Pediatric Dentistry understands that from time to time you may not be able to bring your child to their dental appointment. This consent gives us the permission to treat your child (children) while you are not present.

As legal guardian of the above child, I am allowing the following people to act as my child's guardian to make medical/dental decisions.

_____ _____
Person Acting as Guardian Relationship to Patient

_____ _____
Person Acting as Guardian Relationship to Patient

VOLUNTEER PEDIATRIC DENTISTRY

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FINANCIAL POLICIES

- **All new and emergency patients are required to pay in full at the time of treatment for the first visit.**
- If you do not have dental insurance, full payment is due at the time of each treatment unless other arrangements have been made.
- For your convenience, we accept debit cards, Visa, MasterCard, Discover, and Care Credit.
- If you have dental insurance, it is your responsibility to keep a current copy of your card on file with us at all times and notify us of any changes. **Remember that your insurance policy is a contract between you and your insurance company.** You will be required to pay your estimated portion, including the deductible, at the time of service. Any unpaid insurance claims over 60 days are due and payable by you.
- We are in network with **Delta Dental, Cigna Radius, Renaissance, Ameritas, Metlife and Connection Dental only. Please check with the front desk for changes to this policy.**
- Please note that the parent bringing the child for dental care is financially responsible for all fees incurred regardless of any divorce decree or court order stating otherwise.

Your signature below indicates you have read and understand these policies.

_____ _____

Signature of Parent/Legal Guardian **Date**

Effective date of notice: 10/2017

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

Volunteer Pediatric Dentistry

1516 Coleman Road Suite 201
Knoxville, TN 37909

209 East Emory Road Suite 101
Powell, TN 37849

865-558-8857 (Phone)
865-558-0291 (Fax)

I acknowledge that I received a copy of Volunteer Pediatric Dentistry's Notice of Privacy Practices.

Patient name: _____

Printed Name of Guardian: _____

Signature of Guardian: _____ Date _____