



Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Email _____

Your Child

Child's First _____ M.I. _____
Last _____
Preferred _____ Sex _____
Date of Birth _____ Age _____
SS#SIN _____
School _____ Grade _____
Child's Home Address _____

City _____
State/Prov. _____
ZIP/P.C. _____
Phone _____
Emergency Contact _____

Father

Stepfather Guardian

First _____ M.I. _____
Last _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS#SIN# _____
Date of Birth _____
Employer _____
Occupation _____
DL# _____

Mother

Stepmother Guardian

First _____ M.I. _____
Last _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS#SIN# _____
Date of Birth _____
Employer _____
Occupation _____
DL# _____

Primary Dental Insurance

Insured's name _____ Relationship _____

Date of Birth _____ SS#SIN _____ Employer _____

Ins. Company _____ Group # _____ ID# _____

Additional Insurance Insured's Name _____ Relationship _____

Date of Birth _____ SS#SIN _____ Employer _____

Ins. Company _____ Group# _____ ID# _____

Responsible Party

First _____ M.I. _____

Last _____

Relationship _____

Address _____

Home Phone _____

Work Phone _____ Ext. _____

Cell Phone _____

Parent's Marital Status

Single Divorced

Married Widowed

Separated

How did you hear about us?

Health History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following Questions completely.

Health History

Has your child had difficulty with previous visits? _____
Has your child ever had sleep apnea or snore while sleeping?

Has your child ever had any of the following:

- | | |
|---|--|
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital Heart Defect <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Handicaps/Disabilities <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Convulsions/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No | ADHD/ADD <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autism <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Previous Surgeries Yes No (if yes, what?) _____

Please explain any medical problems that your child has

Please list any medications your child may be taking

Please list any medications your child may be allergic to

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____

Physician's Number _____

Child's Date of Birth _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/finger Yes No

Suck/bite lips Yes No

Bite/Chew Nails Yes No

Chew Hard Objects (pencils, etc.)..... Yes No

Grind teeth Yes No

Clench Jaws Yes No

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X _____
Signature of parent or parent/guardian if minor

Date

AUTHORIZATION FOR TREATMENT

In my ABSENCE I hereby authorize _____
_____.

(Please list above, all persons who will be allowed to bring your child to the office for treatment)

to accompany (child's name) _____ for necessary preventative
and/or restorative appointments to Dickson Pediatric Dentistry, PLLC as deemed by Dr. John Stritikus, Dr. Justin Robbins,
their associates and DPD PLLC staff. These procedures could include photographs, x-rays, fluoride treatments, nitrous
oxide, possibly even sedation medications. The aforementioned person has my full permission to make decisions
concerning treatment of my child, both the day of the appointment and any future appointments. As witnessed by my
signature, I will indemnify and hold harmless Dr. John Stritikus, Dr. Justin Robbins, their associates and DPD PLLC staff,
for all claims arising out of my consent for my child to be treated.

Signature of Parent or Legal Guardian

Print name of Parent or Legal Guardian

Print Name of Patient

Date

Dickson Pediatric Dentistry, PLLC

Your Privacy Is Important To Us

Acknowledgment of Receipt of Notice of Privacy Policies

I, _____, have received a copy of the Notice of Privacy Practices of Dickson Pediatric Dentistry, PLLC. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as well as my dependent's, as authorized in the Patient Consent Form.

Patients Name (print)

Address

Parent/Guardian (print)

Date

Parent/Guardian Signature

Please check your preferred means of communication:

- You may contact me at my home telephone number _____
- You may contact me on my mobile telephone number _____
- You may contact me at my work telephone number _____
- You may send me an email at: _____
- Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____ Date Added/Removed: _____
2. _____ Date Added/Removed: _____
3. _____ Date Added/Removed: _____
4. _____ Date Added/Removed: _____

For Office Use Only

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

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining the acknowledgement
- Other (Please Specify) _____

Staff Person Initials _____

Doctor Treatment Authorization

Thank you for choosing Dickson Pediatric Dentistry as you child's dental care provider. Our main focus at Dickson Pediatric Dentistry is to ensure that your child has a positive dental experience. Our doctors are uniquely trained to care for the oral health and dental development of infants, children, adolescents, and special needs patients.

By signing below, I hereby understand and authorize **Dr. John Stritikus, Dr. Justin Robbins, and their associate dentists** employed by Dickson Pediatric Dentistry to perform any and all necessary preventive and/or restorative procedures that they deem necessary, with the consent of the parent or legal guardian. These procedures may include, but are not limited to photographs, x-rays, fluoride treatments, fillings, extractions, crowns, the administering of nitrous oxide and/or sedation medications, and other dental procedures.

Should you have any reservations, please see the receptionist. Otherwise, please sign the below authorization.

Parent or Legal Guardian

Print Name of Parent or Legal Guardian

Print Name of Patient

Date

Office Policy & Patient Consent for Minors

Thank you for choosing Dickson Pediatric Dentistry, PLLC as your child's dental care provider. Our dental health team is committed to excellence in dental care in a friendly, comfortable environment. It is very important to us as your dental care provider to utilize every means necessary to provide the best dental care possible. We ask that when you have an appointment, please call and confirm the appointment to ensure that we will still have availability. Unconfirmed appointments are not guaranteed and can be given away in the case of an emergency. However, confirmed appointments can be counted against you if the appointment is not kept or if we are not notified within 24 hours of the appointment. After 3 missed appointments, you may be asked to find another provider.

Insurance

Most procedures are covered by TennCare. Procedures not covered (or claims denied due to ineligibility) by TennCare have to be paid by the parents and/or guardians. It is your responsibility to make certain your TennCare coverage is in force before your appointment.

At DPD PLLC, we are not 'signed up' with all insurance companies. It is your responsibility to make certain your insurance plan will pay for your visit. Of course we will be happy to assist you, however, please understand your insurance is contracted between you and the insurance company. We are the third party and have limited ability to act on your behalf. Upon signature of this policy & consent form, you authorize the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and radiographs about the patient's medical history, services rendered, or recommended treatment. You also authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to your insurance company, on your behalf or the patient's behalf with your name listed as "signature on file" and assign to the practice the insurance benefits, providing assignment is accepted, You are responsible for payment regardless of the coverage provided. Any account not paid in full within 90 days will be subject to collection fees. The fees incurred will be the responsibility of the parents and/or guardians. These fees may include, but are not limited to, returned check fees, attorney fees, and court costs.

Clinical Consent

As the parent/legal guardian of the minor patient, I authorize Dickson Pediatric Dentistry, PLLC to perform all recommended treatment on the patient.

I authorize the practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively "diagnostic material") as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payors and/or other health professionals.

I authorize the practice to use my child's photos and/or x-rays for educational purposes and clinical presentations as the practice deems appropriate. The patient's confidential information will never be disclosed.

We are required to inform you that our office is equipped with a video surveillance camera system. This system was acquired to provide parents/guardians with the comfort and assurance of having the opportunity to observe their children during dental procedures.

I have read this Patient Consent and agree to the terms and conditions herein

Patient's Name: _____

DOB: _____

Signature of Parent/Guardian: _____

Date: _____

Relationship to Patient: _____

Address: _____