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 ____
SSN_____
Child's Home Address_____
_____
City _____
State/Prov. _____
ZIP/P.C. _____

☐ Mother ☐ Guardian

First_____ M.I.___
Last_____
Home Phone_____
Work Phone_____
Cell Phone _____
SSN_____
Date of Birth_____
Employer_____
Occupation_____
☐ Address Same as Patient
Address_____
City _____
State_____ZIP_____

☐ Father ☐ Guardian

First_____ M.I.____
Last_____
Home Phone_____
Work Phone_____
Cell Phone _____
SSN_____
Date of Birth_____
Employer_____
Occupation_____
☐ Address Same as Patient
Address_____
City _____
State_____ZIP_____

Responsible Party

First _____ M.I._____
Last _____
Relationship _____
Address _____
_____
Home Phone _____
Work Phone_____ Ext._____
Cell Phone_____

☐Same as Mother/Guardian ☐Same as Father/Guardian

Pediatrician Information

Child's Physician _____
Physician's Number_____

Parent's Marital Status

☐Single ☐Divorced
☐Married ☐Widowed
☐Separated

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 ever had any of the following:

Asthma	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No
Hepatitis	☐ Yes ☐ No	Handicaps/Disabilities	☐ Yes ☐ No
HIV/AIDS	☐ Yes ☐ No	Convulsions/Epilepsy	☐ Yes ☐ No
Hemophilia	☐ Yes ☐ No	Abnormal Bleeding	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
ADHD/ADD	☐ Yes ☐ No	Seasonal Allergies	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Developmental Delay	☐ Yes ☐ No

Is your child ALLERGIC TO any of the following:

LATEX	☐ Yes ☐ No	Red Dye	☐ Yes ☐ No
NUTS	☐ Yes ☐ No	Augmentin	☐ Yes ☐ No
Cillins	☐ Yes ☐ No	Bactrim	☐ Yes ☐ No
Sulfa Drugs	☐ Yes ☐ No	Keflex	☐ Yes ☐ No

Please list any additional allergies your child may have. _____ _____ _____

How did you hear about us?

_____

_____

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Has your child had difficulty with previous visits? ☐ Yes ☐ No

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	☐ Yes ☐ No
Grind Teeth	☐ Yes ☐ No
Clench Jaws	☐ Yes ☐ No

Health History cont'd

Has your child ever had sleep apnea? ☐ Yes ☐ No

Snore while sleeping? ☐ Yes ☐ 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

_____

_____

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.

X_____

Signature of parent or parent/guardian of minor

_____

Date

Authorization for Personal Health Information

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: _____

In my ABSENCE I hereby authorize the above person/people to accompany my child/children 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. 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.

Acknowledgment of Receipt of Notice of Privacy Policies

Your Privacy Is Important To Us

I have been given the option to receive or decline a copy of the Notice of Privacy Practices of Dickson Pediatric Dentistry, PLLC and I am aware that it is posted on site. 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.

_____ _____
Print name of Parent/Legal Guardian Relationship to Patient

_____ _____
Signature of Parent/Guardian Date

_____
Print Name of Patient(s)

Office Policies & Consent Form

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 and give your child 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. 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.

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.

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

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 form and agree to the terms and conditions herein

Patient's Name: _____ Date: _____

Signature of Parent/Guardian: _____ Relationship to Patient: _____