

Welcome !

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



PATIENT INFORMATION

Child's Name _____
Last Name First Name Middle Initial

Male Female Age _____ Birthdate ____ / ____ / ____ Nickname _____ Hobbies _____

Home Address _____
Street Apt.# City State Zip

Mailing Address _____
Street City State Zip

Home Phone # _____ Mom Cell # _____ Dad Cell # _____

Does your child have Georgia Medicaid/Peachcare? Yes No ID# _____

Whom may we thank for referring you? _____

PARENT'S INFORMATION

<input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Guardian Name _____ Address (if different from patient's) _____ _____ Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small> Employer _____ Social Security # _____ Birthdate ____ / ____ / ____ Do you have dental insurance coverage for a minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Co.: _____ Phone No. _____ Claims Address: _____ _____ Group # _____ Policy/ I.D. # _____	<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian Name _____ Address (if different from patient's) _____ _____ Home Phone _____ Work Phone _____ <small>(if different from above) (if different from above)</small> Employer _____ Social Security # _____ Birthdate ____ / ____ / ____ Do you have dental insurance coverage for a minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Co.: _____ Phone No. _____ Claims Address: _____ _____ Group # _____ Policy/ I.D. # _____
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DENTAL HISTORY

Date of last visit to a dentist ____ / ____ / ____ Last Cleaning/Fluoride ____ / ____ / ____ Last X-Rays ____ / ____ / ____

Has child complained about dental problems? Yes No Is fluoride taken in any form? Yes No

Does child brush teeth daily? Yes No Any injuries to mouth, teeth, head? Yes No

Does child floss every day? Yes No Any unhappy dental experiences? Yes No

Any mouth habits? thumbsucking nail biting mouth breathing pacifier sleeping with bottle

other (please explain) _____



Please Complete Both Sides

MEDICAL HISTORY

Child's Physician _____ City/State _____ Phone _____

Date of last physical examination ____ / ____ / ____ Current Medical Conditions: _____

List all allergies: _____

	Yes	No	
Has child ever been diagnosed with a heart murmur?.....	<input type="checkbox"/>	<input type="checkbox"/>	Is Pre-Medication required? _____
Receiving any medication or drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	List Medications: _____
Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	If so, why? _____
Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	List Surgeries: _____
Is there excessive bleeding when cut?.....	<input type="checkbox"/>	<input type="checkbox"/>	Handicaps/Disabilities: _____

HAS CHILD EVER HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK (✓)

<input type="checkbox"/> ADD/ADHD	<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> AIDS/HIV	<input type="checkbox"/> Cancer/Tumors	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Mumps
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney/Liver Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Asthma	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Fainting	<input type="checkbox"/> Learning Disability	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Artificial Heart Valves	<input type="checkbox"/> Congenital Heart Defect	<input type="checkbox"/> Hearing Impairment	<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Autism	<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Mental Problems	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other: _____				

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? _____

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

CONSENT FOR TREATMENT

The information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Kelly and/or associates to perform the necessary dental procedures including, but not limited to the use of Nitrous Oxide (laughing gas), Lidocaine (Novacaine-like), and any necessary x-rays on my child. I also consent to photographs and flash or study models for educational/study purposes. **ALL PROCEDURES WILL ALWAYS BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT.**

Parent/Guardian Signature _____ Date _____



FINANCIAL INFORMATION



- Our policy requires payment in full at the time of service. Insurance reimbursement for covered services are subject to maximum allowable fees, in addition to plan deductible and coinsurance. Your responsibility is estimated and due at treatment visits. It is the parent/guardian responsibility to see that benefits are paid promptly.
- If account is not paid within 90 days, you will be liable for collection fees, legal fees, court costs, interest charges and any other expenses incurred in collecting the account.
- I hereby authorize payment directly to Diane C. Kelly, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.
- A written warning will result after a first missed appointment and a penalty will be assessed for any future missed appointments. This penalty is described in detail on our "appointment policy" form, which must be signed by a parent or guardian.

Parent/Guardian Signature _____ Date _____