

PEDIATRIC DENTAL SPECIALISTS, P.C.

David H. Brantley, DDS / John W. Spratling, DMD / Will Brantley, DMD

Child's full name _____ Age _____ Birthdate _____ Sex F M

Name child goes by _____

Child's Home Address _____

City _____ State _____ Zip _____ Home Phone # _____

Child's Social Security # _____ School _____ Grade _____

Name & age of sibling's _____

Home E-mail Address _____

Emergency Contact Name _____ Phone Number _____

How did you hear about our office? _____

Who is your family dentist? _____

Minors not accompanied by a parent or legal guardian cannot have treatment done without signed authorization

Do parents live together? Yes No If not, with whom does the child live? _____

PARENT OR GUARDIAN INFORMATION

MOTHER STEPMOTHER GUARDIAN

Name _____ DOB _____ Cell Phone # _____

Employer _____ Occupation _____

S.S. # _____ Work E-mail _____ Work # _____

PARENT OR GUARDIAN INFORMATION

FATHER STEPFATHER GUARDIAN

Name _____ DOB _____ Cell Phone # _____

Employer _____ Occupation _____

S.S. # _____ Work E-mail _____ Work # _____

Our office communicates with patients electronically, via e-mail and text messaging, and automatic telephone dialing. Please inform us of your preference of communication. Check all that apply.

E-mail-For appointment confirmations and communication.

Preferred E-mail address _____

Text Message-For appointment confirmations and communications

Parent/Guardian text# _____

Please do not contact me by calling, e-mail, nor text

METHOD OF PAYMENT

Fees for dental services are due at time of treatment. All account balances which have not been paid within 30 days become the responsibility of the parent/guardian.

Check, cash, credit/debit card, Care Credit

Dental Insurance (We are participating providers with Met Life, United Concordia and premier providers with Delta Dental **ONLY**). As a courtesy, our office will file for insurance benefits for treatment rendered. Any deductibles, co-payments, or balances not covered by your insurance must be paid in full at treatment visit.

GA. Medicaid # _____ GA. Peachcare # _____ Wellcare # _____

CHILD'S MEDICAL HISTORY

Child's full name _____ Birthdate _____

Name of child's pediatrician or physician _____ Telephone # _____

Has your child been hospitalized since birth? Yes No If yes, explain _____

Is your child allergic to any medications or foods? Yes No If yes, explain _____

Is your child presently taking any medication? Yes No If yes, explain _____

Please check any of the following medical conditions your child has experienced:

- | | | | |
|---|----------------------------------|---|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Inhaler | <input type="checkbox"/> Special Needs | <input type="checkbox"/> Convulsions/Epilepsy |
| <input type="checkbox"/> Anemia | | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Hepatitis | | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Ear Problems |
| <input type="checkbox"/> Abnormal Bleeding | | <input type="checkbox"/> Nose/Throat Disorder | <input type="checkbox"/> Tubes in Ears |
| <input type="checkbox"/> Blood Disease | | <input type="checkbox"/> Tonsils/Adenoids Removed | <input type="checkbox"/> Speech/Vision Problems |
| <input type="checkbox"/> Diabetes | | <input type="checkbox"/> Cancer/Tumors | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Tuberculosis | | <input type="checkbox"/> Stomach/Kidney Problems | <input type="checkbox"/> Emotional Disorder |
| <input type="checkbox"/> Skin Disorder | | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Latex Allergy |
| <input type="checkbox"/> Autism Spectrum Disorder | | <input type="checkbox"/> Seasonal Allergies | <input type="checkbox"/> Female patients: Are you pregnant? |
| | | | <input type="checkbox"/> Other _____ |

Please explain any medical condition(s) or concerns that your child has _____

CHILD'S DENTAL HISTORY

1. Is your child on a bottle? Yes No If no, at what age was it discontinued? _____

2. Is your child a thumb/finger sucker or ever used a pacifier? Yes No Age discontinued? _____

3. Is your primary source of water from a well? Yes No

4. Has your child ever been seen by a dentist? Yes No

5. If so, please give the date of last dental care: _____ Previous Dentist Name: _____

6. Has your child had problems with previous dental treatment? Yes No

7. If yes, please explain: _____

8. Has your child had any type of injury to his/her teeth? Yes No

9. If yes, please explain: _____

10. Is your child in pain today? Yes No If yes, please explain: _____

12. Does your child have a dental condition about which you are especially concerned? Yes No

13. If yes, please explain: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I am the parent or legal guardian of this patient, and have the legal right to authorize medical and dental care on their behalf. 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 and information. I authorize the dentist and dental staff to perform the necessary dental services my child may need. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I authorize the dentist to release any information, including the diagnosis and records of treatment or examination rendered to my child during the period of such care, to third party payers and/or other health practitioners. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parent/Guardian _____ Date _____ Relationship _____



Unaccompanied Minor Form

I am the parent/legal guardian of _____ who is under 18 years of age. Due to (Reason) _____, I may not be able to accompany my child when he/she requires dental services. I authorize the health care providers of Pediatric Dental Specialists, P.C., to provide my child with dental services as indicated when accompanied by any of the following individuals:

Name

Relationship to child

Name

Relationship to child

I further understand that this consent form will be valid and remain in effect until I revoke it in writing.

If my child is 16 years old or older, I allow them to come unaccompanied by an adult for dental treatment.

In case of an emergency during my absence, please contact: **(PLEASE PRINT)**

Name: _____

Address: _____

Telephone: _____

I have read and understand the contents of this consent form, which I voluntarily sign:

_____ Date _____

Signature of Parent/Legal Guardian of Minor Patient

(PLEASE PRINT)

Name of Parent/Legal Guardian: _____

Address: _____

Telephone Number: _____ (cell) _____ (Work)