PEDIATRIC DENTAL SPECIALISTS, P.C.

David H. Brantley, DDS John W. Spratling, DMD Will Brantley, DMD Rachel Elvis, DMD

Child's full name_____Age_____Birthdate_____ Sex F M

Name child goes by_____

Parent/Child's Home Address_____

City_____State_____Zip_____Home Phone # _____

Home E-mail Address_____

Child's Social Security # _____School_____Grade_____

Name & age of sibling's _____

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 without signed authorization
Do parents live together? ___Yes ___ No If not, with whom does the child live? _____

Parent / Guardian Information ____Mother ____Stepmother ____Guardian

Name_____DOB_____Cell Phone #_____

Employer_____Occupation _____

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

Parent / 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, text messaging, and automatic telephone dialing. Confidentiality of electronic communications cannot be guaranteed. By signing this form, I understand that Pediatric Dental Specialists is not responsible for the confidentiality or security of electronic communications sent to or by me. If my contact information changes or I wish to revoke my consent, I agree to notify Pediatric Dental Specialists in writing or in person.

Preferred e-mail address -For appointment confirmations and communication_____
Preferred text message # -For appointment confirmations and communications. #_____
_____Please do not contact me by e-mail, text, or telephone call

METHOD OF PAYMENT
____ Payment in full at time of treatment - Cash, Debit/Credit card, Care Credit

____ Dental Insurance (We are participating providers with United Concordia **ONLY).** As a courtesy, our office will file for insurance benefits. Any deductibles, co-payments, or balances not covered by your insurance must be paid in full by the parent accompanying the patient when treatment is rendered. After 30 days, no further attempt will be made by our office to collect from the insurance company and payment is expected. All account balances which have not been paid within 30 days become the responsibility of the parent/guardian.

Georgia Medicaid #_____ Peachstate #_____

Please see other side

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:

___Asthma ____Inhaler
___ Anemia
___ Hepatitis
___ Abnormal Bleeding
___ Blood Disease
___ Diabetes
___ Tuberculosis
___ Skin Disorder
___ Autism Spectrum Disorder
___ Special Needs
___ Heart Condition
___ Lung Disease
___ Nose/Throat Disorder
___ Tonsils/Adenoids Removed
___ Cancer/Tumors
___ Stomach/Kidney Problems
___ Liver Problems
___ Seasonal Allergies
___ Convulsions/Epilepsy
___ HIV/AIDS
___ Ear Problems
___ Tubes in Ears
___ Speech/Vision Problems
___ ADD/ADHD
___ Emotional Disorder
___ Latex Allergy
___ Female patients: Are you pregnant?
___Other_____

Please explain in detail any medical condition(s) or concerns that your child has_____

_____

Child's Dental History

Is your child on a bottle? ____Yes ____No If no, at what age was it discontinued? _____
Is your child a thumb/finger sucker or ever used a pacifier? ____Yes ____No Age discontinued? _____
Is your primary source of water from a well? ___Yes ___No
Has your child ever been seen by a dentist? ____Yes ___No
If so, please give the date of last dental care: _____Previous Dentist Name: _____
Has your child had problems with previous dental treatment? ___Yes ___No

If yes, please explain: _____

Has your child had any type of injury to his/her teeth? ___Yes ___No

If yes, please explain: _____

Is your child in pain today? ___Yes ___No If yes, please explain: _____

Does your child have a dental condition about which you are especially concerned? ___Yes ___No
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 or dental status. I authorize the dentist and dental staff of Pediatric Dental Specialists 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_____

Printed Name of Parent/Guardian _____Relationship to patient_____