

# 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 communications \_\_\_\_\_

Preferred text message # -For appointment confirmations and communications # \_\_\_\_\_

**METHOD OF PAYMENT**

\_\_\_ Payment in full at time of treatment - Cash, Debit/Credit card, Care Credit

\_\_\_ Dental Insurance - 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/guardian 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. Our office is not contracted with any dental insurance companies.

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:

<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 in detail any medical condition(s) or concerns that your child has \_\_\_\_\_

## **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 \_\_\_\_\_