

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:

☐ Asthma	☐ Inhaler	☐ Special Needs	☐ Convulsions/Epilepsy
☐ Anemia		☐ Heart Condition	☐ HIV/AIDS
☐ Hepatitis		☐ Lung Disease	☐ Ear Problems
☐ Abnormal Bleeding		☐ Nose/Throat Disorder	☐ Tubes in Ears
☐ Blood Disease		☐ Tonsils/Adenoids Removed	☐ Speech/Vision Problems
☐ Diabetes		☐ Cancer/Tumors	☐ ADD/ADHD
☐ Tuberculosis		☐ Stomach/Kidney Problems	☐ Emotional Disorder
☐ Skin Disorder		☐ Liver Problems	☐ Latex Allergy
☐ Autism Spectrum Disorder	☐ Seasonal Allergies		☐ 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 _____