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www.adventurepediatricdental.com

6413 Lee Hwy Suite 119
Chattanooga, TN 37421

Adventure Pediatric Dentistry

PATIENT AND FAMILY INFORMATION

Patient Name :_____

Preferred Name:_____ Age:_____

Date of Birth:_____ Social Security Number:_____

Address:

_____

Street

_____

City State Zip Code

Gender: ☐Male ☐Female ☐Other

Parent/Guardian #1_____ Parent/Guardian #2_____

DOB _____ DOB _____

SSN_____ SSN_____

Employer_____ Employer_____

Phone _____ Phone _____

Parent's Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced

Who has legal custody of patient? _____

Who is the primary contact?_____

Preferred Phone: _____(Mobile or Home)

Email: _____

Referral Source:

☐Internet Search/Website ☐Insurance directory
☐Facebook/Social Media ☐Patient Referral
☐Dentist/Pediatrician Referral ☐Other:_____

Preferred Method(s) of Contact: ☐Home Phone ☐Mobile Phone ☐Text Message

May we text/email you regarding appointment times and practice information? ☐Yes ☐No

Payment Information

Person Responsible for payment on the account? _____

Dental Insurance? ☐ Yes ☐ No If yes, please complete below

Primary Insurance _____ Secondary Insurance_____

Subscriber's Name _____ Subscriber's Name _____

Insurance Address _____ Insurance Address _____

Subscriber's DOB_____ Subscriber's DOB_____

SSN or ID# _____ SSN or ID# _____

Group #_____ Group #_____

Consent for Dental Treatment

I request and authorize the team members of Adventure Pediatric Dentistry to clean, examine and provide dental treatment on my child's teeth. I also authorize dental radiographs that may be necessary to diagnose and or treat my child's dental problems. I will allow photographs to be taken for diagnostic or educational purposes. I understand that should the patient become uncooperative during dental procedures with movement of head, arms and or legs, dental treatment cannot be safely provided. During such disruptive behavior it may be necessary for the assistant(s) and or doctor to hold the patient's hand, stabilize the head or control leg movements for their safety. I also understand the routine use of "tooth pillows" (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their mouth that could harm them. I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated. I understand that the information that I have given above is correct to the best of my knowledge and that I will not hold Adventure Pediatric Dentistry responsible for any mistakes in omission that I have made in the completion of this form.

I have read and agree to the treatment policy outline above. By signing, I am giving consent for my child (or self if over the age of 18) to receive care at Adventure Pediatric Dentistry by the dentist and dental team.

Printed Name:_____ Relationship:_____

Signature:_____ Date:_____

Insurance and Financial Policy

I assume financial responsibility for all dental treatment and medications provided for my child. I understand that payment is expected on the date services are provided.

As a courtesy to you, we will assist you with your benefit eligibility before treatment to help you calculate costs and maximize insurance. We are happy to submit electronic claims and pre-estimates to see that you receive the full benefits of your coverage. ***However, we cannot guarantee any estimated coverage, and you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.*** Please remember that your insurance policy is a contract between you and your insurance provider. It is your responsibility to provide us all necessary insurance identification, understand your eligibility and benefits, and notify us immediately of any changes. It is also your responsibility to ensure that our office is a participant with your insurance plan.

HIPAA ACKNOWLEDGMENT

I acknowledge that I have received a copy of this dental practice's HIPAA Notice of Privacy Practices.

PARENT/GUARDIAN POLICY

I acknowledge that the policy of Adventure Pediatric Dentistry is for a legally responsible parent or guardian to be present for all dental appointments. If someone other than the parent or legal guardian accompanies your child to their visit, we reserve the right to reschedule the appointment. If advance notice is given (at least 48 hours) and we can obtain the necessary paperwork prior to the scheduled visit, we may accommodate your needs on a case by case basis. Certain types of visits (including sedation) always require a parent or legal guardian to be present for the entirety of the visit.

CANCELLATIONS AND NO-SHOWS

In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to make your appointment. Any appointment(s) not cancelled at least 24 hours in advance is subject to a $50 cancellation fee. We cannot reschedule your appointment until the fee is paid. Continued cancellations and no-shows can result in dismissal from the practice.

I have read and agree to the insurance and financial policy outline above. I understand and fully agree that I am responsible for my account balance. I agree that if turned over to a collection source, I will be responsible for all fees above and beyond my account which may include attorney fees associated with an external collection company. I understand that if my account becomes overdue or uncollected, it can result in cancelled appointment and/or dismissal from the practice. Lastly, if insurance is involved, I take full responsibility for any disputes that I may have with their payment schedule.

Parent's Name:_____ Relationship:_____

Signature:_____ Date:_____

Photo Consent

As part of your child's medical record, we take a face photograph for identification purposes at the first appointment and periodically thereafter. These photographs are placed in the patient record as protected health information and remain confidential.

I give my consent for Adventure Pediatric Dentistry to take photographs of my child for the medical record. I understand these photos are protected health information and will not be used for any marketing, educational, or promotional use.

Patient Name:_____ Patient DOB:_____

Legal Guardian's Printed Name:_____ Relationship:_____

Legal Guardian's Signature:_____ Date:_____

Occasionally we take photographs of patients and team members for marketing and /or social media purposes. We must have written permission to use such photos for promotion, and you have the right to decline such photographs and their use. Pictures placed on our website and/or social media pages (Facebook, Instagram) are accessible to anyone with internet access.

PUBLICATION OF SUCH PHOTOS IS COMPLETELY VOLUNTARY.

May we use your child's image on the internet (www.adventurepediatricdental.com, Social Media)? ☐Yes ☐No

May we use or attach your child's first name to social media photos? ☐Yes ☐No

Printed Name:_____ Relationship:_____

Signature:_____ Date:_____

Medical History

Child's Full Name:_____ DOB:_____

Gender: ☐ Male ☐ Female ☐ Transgender Race/Ethnicity:_____

Height:_____ Weight:_____

Name/Phone of Primary Physician:_____

Name/Phone of any Medical Specialist:_____

Is your child being treated by a physician at this time?	☐ Yes ☐ No
If yes, describe reason:_____	
Is your child taking any medications (prescriptions or over the counter)?	☐ Yes ☐ No
If yes, list name/dosage/frequency/reason:_____	
Has your child ever been hospitalized or undergone surgery?	☐ Yes ☐ No
Has your child ever had a reaction to medication, foods, metals, latex or dyes?	☐ Yes ☐ No
If yes, list and describe reaction:_____	
Is your child up to date on immunization?	☐ Yes ☐ No

Please CIRCLE condition and mark YES if your child has a history of the following:

Complications before or during birth, prematurity, birth defects or syndromes	☐ Yes ☐ No
Problems with physical growth, development, or failure to thrive	☐ Yes ☐ No
Sinusitis, chronic tonsil infections, sleep apnea, or snoring	☐ Yes ☐ No
Congenital heart defect/disease, heart murmur, rheumatic fever or disease	☐ Yes ☐ No
Irregular heartbeat, high or low blood pressure	☐ Yes ☐ No
Asthma, reactive airway disease, cystic fibrosis, or breathing problems	☐ Yes ☐ No
Frequent colds, coughs, or history of pneumonia	☐ Yes ☐ No
Jaundice, hepatitis, or liver problems	☐ Yes ☐ No
Gastroesophageal reflux disease (GERD), stomach ulcers, or intestinal problems	☐ Yes ☐ No
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	☐ Yes ☐ No
Prolonged diarrhea, unintentional weight loss/gain, or eating disorder	☐ Yes ☐ No
Bladder or kidney problems	☐ Yes ☐ No
Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	☐ Yes ☐ No
Rash/hives, eczema, or skin problems	☐ Yes ☐ No
Impaired vision, hearing, or speech	☐ Yes ☐ No
Developmental disorders, learning problems/delays, or intellectual disability	☐ Yes ☐ No
Cerebral palsy, brain injury, epilepsy, or seizures	☐ Yes ☐ No
Autism or autism spectrum disorder	☐ Yes ☐ No
Recurrent or frequent headaches/migraines, fainting or dizziness	☐ Yes ☐ No
Hydrocephaly or placement of a shunt (VP, VA, VV)	☐ Yes ☐ No
Attention deficit/hyperactivity disorder (ADD/ADHD)	☐ Yes ☐ No
Behavioral, emotional, communication, or psychiatric problems/treatment	☐ Yes ☐ No
Abuse (physical, emotional, psychological, or sexual) or neglect	☐ Yes ☐ No
Diabetes, hyperglycemia, or hypoglycemia	☐ Yes ☐ No
Precocious puberty or hormonal problems	☐ Yes ☐ No
Thyroid or pituitary problems	☐ Yes ☐ No
Anemia, sickle cell trait/disease, or blood disorder	☐ Yes ☐ No
Hemophilia, easy bruising, or excessive bleeding	☐ Yes ☐ No
Transfusions or receiving blood products	☐ Yes ☐ No
Cancer, tumor, other malignancy, chemotherapy, or radiation therapy	☐ Yes ☐ No
Bone marrow or organ transplant	☐ Yes ☐ No
Mononucleosis, tuberculosis, scarlet fever, or cytomegalovirus	☐ Yes ☐ No
MRSA, sexually transmitted infections, HIV/AIDS	☐ Yes ☐ No
Any other significant medical history we should be told?	☐ Yes ☐ No

If yes, please describe:_____

_____

_____

Dental History

What is your primary concern about your child's oral health?_____

_____

Does your child have any of the following? If yes, please describe.

Inherited dental anomalies ☐ Yes ☐ No _____

Mouth sore/fever blisters ☐ Yes ☐ No _____

Bad Breath ☐ Yes ☐ No _____

Bleeding gums ☐ Yes ☐ No _____

Cavities/tooth decay ☐ Yes ☐ No _____

Injury to teeth or mouth ☐ Yes ☐ No _____

Clenching or grinding ☐ Yes ☐ No _____

Jaw joint problems (popping) ☐ Yes ☐ No _____

Excessive gagging ☐ Yes ☐ No _____

Sucking habit (fingers, pacifier) ☐ Yes ☐ No _____

Please answer the following questions concerning your child's oral hygiene.

How often does your child brush his/her teeth?
_____times per _____ Does someone help? ☐ Yes ☐ No

How often does your child floss his/her teeth? ☐ Yes ☐ No

_____times per _____ Does someone help?

What type of water does your child drink (city, well, bottled, filtered)?_____

Does your child use fluoridated toothpaste or training toothpaste?_____

How frequently does your child:

Eat candy, cookies, cake, or processed desserts? ☐Never ☐Rarely ☐1-2 times/day ☐ 3/+ times a day

Drink soda, energy drinks, or carbonated drinks? ☐Never ☐Rarely ☐1-2 times/day ☐ 3/+ times a day

Drink juice, fruit punch or box drinks? ☐Never ☐Rarely ☐1-2 times/day ☐ 3/+ times a day

Snack between meals? ☐Never ☐Rarely ☐1-2 times/day ☐ 3/+ times a day

Please answer the following questions:

Does your child participate in sports? ☐ Yes ☐ No List: _____

Does your child wear a mouth guard? ☐ Yes ☐ No Type: _____

Has your child been treated by another dentist? ☐ Yes ☐ No Name: _____

If yes, date of last visit_____ Reason for last visit: _____

_____

Were x-rays taken? ☐Yes ☐ No

Any difficulty with dental treatment? ☐Yes ☐ No