2600 Bell Road
Montgomery, Alabama 36117
Phone: (334) 277-6690
Fax: (334) 277-6721

montgomery pediatric dentistry & orthodontics

prattville pediatric dentistry & orthodontics

460 McQueen Smith Road
Prattville, Alabama 36066
Phone: (334) 358-6411
Fax: (334) 351-0033

THE FOLLOWING INFORMATION IS NECESSARY FOR US TO UNDERSTAND AND ADEQUATELY TREAT YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

PATIENT INFORMATION:

Legal Name _____ Goes By _____ Age _____

Sex _____ Date of Birth _____ Home Phone _____

Address _____
Street City State Zip

Child's Social Security Number _____

Preference of appointment confirmation: Email _____ Text _____ Phone Call _____

Father's Cell #: _____ Mother's Cell #: _____

Person to contact in case of emergency (not living in same household) _____ Phone _____

With whom does patient live _____

Other children in your family that we have seen _____

Other children in your family that we have not seen _____

Child's interests and hobbies _____

School child attends _____

How did you hear about our office? _____

PARENT / GUARDIAN INFORMATION:

Parents' Marital Status: ❑ Married ❑ Widowed ❑ Divorced ❑ Separated ❑ Single

Father:
Name _____

Date of Birth _____ SSN _____

Driver's License # _____ State _____

Employer _____

Address _____

Occupation _____

Business # _____ Ext. _____

Email Address _____

Mother:
Name _____

Date of Birth _____ SSN _____

Driver's License # _____ State _____

Employer _____

Address _____

Occupation _____

Business # _____ Ext. _____

Email Address _____

PRIMARY INSURANCE

Insurance Company _____

Address _____

Contract # _____

Group # _____

Insured's Name _____

Insured's SSN _____

SECONDARY INSURANCE

Insurance Company _____

Address _____

Contract # _____

Group # _____

Insured's Name _____

Insured's SSN _____

MEDICAL & DENTAL HISTORY

Thank you for completing this section in full.

Pediatrician: _____

Medical History	Yes	No
Does your child have any significant health problems?	_____	_____
If so, please explain _____		
Does your child require premedication?	_____	_____
Does your child have regular medical exams?	_____	_____
Is your child up to date with immunizations?	_____	_____
Is your child taking any medications?	_____	_____
If so, please list _____		
Has your child been hospitalized since birth?	_____	_____
If so, then explain _____		
Is your child allergic to any food, medication or latex?	_____	_____
If so, then list _____		
_____		
Has your child ever been diagnosed with any type of heart problem?	_____	_____

_____ Emotional Disorder
_____ Sickle Cell Anemia
_____ Bleeding Disorder
_____ Hearing Disorder
_____ Nervous Disorder
_____ Mental Condition
_____ Speech Disorder
_____ Vision Disorder
_____ Rheumatic Fever
_____ Cerebral Palsy

_____ Kidney Disorder
_____ Liver Disorder
_____ Brain Disorder
_____ Tuberculosis
_____ Down Syndrome
_____ Allergies
_____ Hepatitis
_____ Diabetes
_____ Epilepsy
_____ Asthma

_____ Autism
_____ HIV+
_____ Recurrent Headaches
_____ Transfusions
_____ Leukemia
_____ Cancer
_____ Spina Bifida
_____ Latex Allergy
_____ Pregnant
_____ Other _____

Dental History	Yes	No
Is this your child's first dental visit?	_____	_____
If not, please provide		
Dentist's Name _____ Date of Last Visit _____		
Date of Last X-rays _____		
Has your child had an unfavorable experience at another dental office?	_____	_____
Do you expect your child to be a cooperative patient?	_____	_____
Is your child presently on a fluoride supplement?	_____	_____
Does your child suck fingers or thumb or have a similar habit such as a pacifier?	_____	_____
Has your child ever experienced trauma to the teeth, face, or jaws?	_____	_____
If yes, please explain _____		

What is your water source?
Private Well Public System

Reason for Today's Appointment

Check up and Cleaning Exam Only Evaluate Crowding
2nd Opinion Toothache Other

Is there any additional information that we should be aware of before providing dental care for your child?

_____

GENERAL INFORMATION AND CONSENT

We are pleased to receive your child as a patient in our office and feel honored by the confidence you have placed with us. We sincerely desire to make his or her visits as pleasant as possible. We feel that we can better establish a patient-doctor relationship if our parents and patients are familiar with the service and procedures of this office. Please read and initial each section.

_____ **INITIAL VISIT:** Each child receives a thorough examination on their first appointment. It usually includes a prophylaxis (cleaning of the teeth), topical fluoride, and dental x-rays, if they are needed. Oral hygiene instructions will be given to the patient and reviewed with the parent along with dietary recommendations. We employ all procedures available to reduce radiation risks including thyroid and gonadal lead apron, collimated x-ray machine, and the fastest film available today. We feel that it is extremely important for a child to have a full-mouth x-ray (panorex) starting around the age of 5 or 6 to check for any problems such as extra permanent teeth, congenitally missing teeth, cysts, or eruption problems.

_____ **PARENT POLICY:** We request that a parent, guardian, or other adult accompany the patient to all appointments and remain in the reception room during treatment. We find that children are more cooperative and have a more positive outcome when parents are not present during treatment. There are exceptions to this policy such as children age 2 and under or children with special needs. After treatment, you are welcome to tour our office!

_____ **FLUORIDE:** The standard of care in pediatric dentistry is to apply fluoride at routine recall visits as needed per the doctor's request. Fluoride is a proven agent to assist in the remineralization of enamel and can help reverse the decay process.

I give consent to apply fluoride per the doctor's request.

Signature: _____

I do not give consent to apply fluoride, and I acknowledge that my decision may adversely affect my child's health.

Signature: _____

_____ **X-RAYS:** The standard of care in pediatric dentistry is to take dental x-rays (bitewings, periapical films, and/or panoramic films) at routine recall visits as needed per the doctor's request. Dental x-rays assist the doctor in accurately diagnosing development, eruption, missing teeth, decay, pathology, cysts, and other dental health concerns.

I give consent to take x-rays per the doctor's request.

Signature: _____

I do not give consent to take x-rays, and I acknowledge that my decision may adversely affect my child's health.

Signature: _____

_____ **NITROUS OXIDE (LAUGHING GAS):** Frequently, we will employ the "Happy Air Mask" (nitrous oxide) to help reduce anxiety and fear of dental operative procedures. It is tremendously effective when treating children and is very safe.

_____ **COMPOSITE (WHITE) FILLINGS:** Our office only places white, composite resin fillings. We do not use the amalgam (silver) filling material. Please be aware that insurance companies may not cover the composite.

_____ **TREATMENT:** We intend to treat your child for their scheduled treatment, but on some occasions the treatment plan may change after work has started. The parent or adult present will be advised of the change before treatment is rendered. We request that a parent or guardian (or other adult) accompany the patient to all appointments and remain in the reception room during treatment. We find that children are more cooperative and have a more positive outcome when parents are not present during treatment. There are exceptions to this policy, such as children age 2 and under or children with special needs. After treatment you are welcome to tour our office!

_____ **ORTHODONTICS:** At each six month hygiene appointment, your child will be checked for proper eruption of teeth and/or any malocclusion that may be developing. We will inform you of any treatment that we feel is necessary for your child. For your convenience we have an orthodontist, Robert H. Owen, D.M.D., M.S., on staff who would be happy to evaluate, discuss, and treat any of your child's orthodontic needs.

_____ **HOSPITAL TREATMENT:** Some young or special needs children requiring extensive treatment would benefit by having their work done under general anesthesia in a hospital setting. If we feel this is a necessary way to treat your child, we will thoroughly discuss this option with you.

Finally, our office operates on "children's time" which means that we occasionally have a delay in our schedule as we take a few additional minutes with patients who need extra attention from our caring doctors and staff. We welcome you to our office and look forward to taking care of all of your child's dental health needs.

FINANCIAL POLICY

Non-Insurance Patients: Payment is due when services are rendered.

Insurance Patients: Dental insurance, which provides an important benefit for many patients, is a contract between you, your insurance company, and your employer. We are not a party to that contract, but we file for benefits as a courtesy to you. We encourage you to familiarize yourself with your insurance policy benefits, as benefits vary greatly among different plans and levels of coverage. All non-covered services, co-pays, and deductibles are payable at the time services are rendered. We will file electronic claims for insurance benefits on your behalf for covered services rendered with payment assigned to Montgomery and Prattville Pediatric Dentistry & Orthodontics. In order to receive this benefit, you must provide all insurance information to us for proper filing of a complete and accurate insurance claim. Any balance remaining after insurance has paid in full will be billed to you and is due upon receipt.

We accept personal checks, cash, money orders, major credit cards, and Care Credit.

I have read, understand, and will comply with the above financial policy. I authorize the release of dental, medical, and payment history information for insurance claims processing. I agree to pay the entire balance due after 60 days if not paid by my insurance company. I accept the fee charged as a lawful debt. I promise to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution of the laws of the State of Alabama, or any other state.

Signature _____ Date _____

ACKNOWLEDGEMENT OF NOTICE OF HIPAA AND PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that my child's confidential medical records and health information will be used to:

- Conduct, plan, and direct treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

A complete copy of the Notice of Privacy Practices containing a complete description of the uses and disclosures of my PHI is available upon request. I understand that you have the right to change the terms of the Notice of Privacy Practices from time to time and that I may contact you at any time to obtain a current copy of the Notice of Privacy Practices. I may revoke my authorization to release information in writing at any time, and any disclosure prior to the date revoked is not affected.

I hereby consent that medical and dental information and treatment can be discussed with the following person or persons. An example is your spouse, parents, etc. If you want this information discussed only with you, please leave the following lines blank.

_____ _____

_____ _____

Signature _____ Date _____

CONSENT FOR TREATMENT

As parent or guardian of, _____, a minor, I give permission for him/her to have diagnostic procedures and treatment performed by the dentists and hygienists of Montgomery and Prattville Pediatric Dentistry & Orthodontics as is necessary for proper dental care. This consent shall remain in force and effect until cancelled by either party.

Signature _____ Date _____