Patient Registration

Last Name: _____ First Name: _____ Sex: □ Male □Female

DOB: _____ Cell Phone Number:_____ Home Phone:_____

Email Address:_____ Soc. Sec. #: _____

Address: _____ City, State: _____ Zip: _____

How did you hear about us? _____Referred By: _____

Parent/Legal Guardian Info

Relationship to patient: _____First Name: _____ Last Name: _____
DOB: _____ Soc. Sec. #: _____ Preferred Language: _____

Does your child have any medical conditions? If yes, please explain:_____
Please write down all medications your child takes on a daily basis: _____
Does your child have any allergies (non-drug related) &/or (medications?)? If yes, please explain:_____
_____
Has your child ever been hospitalized? If yes, Please explain:_____
Has your child ever had any surgeries? If yes, Please explain:_____
Has your child or any relative had problem with general anesthesia? If yes, Please Explain:_____
Your child physicians name/office:_____ Phone Number:_____

Dental Information

1. Is this your child's first visit to the dentist? □Yes □No
2. Has your child complained about dental problems? □Yes □No
3. When was your child's last trip to the dentist? _____
4. Has your child had an unhappy dental experience? □Yes □No
5. Who brushes your child's teeth? _____ How often? _____
6. Do you drink well water, city water, or bottled water? _____
7. Is your child going to sleep with a bottle? □Yes □No
8. What does the bottle contain □Water □Milk □Formula □Juice □Other _____
9. Is your child presently breast-feeding? □Yes □No
10. Any oral habits (thumb sucking, pacifiers, nail biting, etc.)? _____
11. Any history of injuries to mouth, teeth, or head? □Yes □No

Please explain "YES" answers above: _____

The statements on both sides of this form are, to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to treatment. I hereby authorize the Doctor and staff to provide examination, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

Signature of Parent or Legal Guardian:_____ Date:_____

Pediatric Dentistry General Consent for Dental Procedures and Acknowledgement of Receipt of Information

I hereby authorize and direct **Dr. Landon Sears** and staff to perform upon my child/children all necessary dental services he/she/they may need; including one or more procedures: Radiographs of teeth and jaws, cleaning of teeth and application of fluoride, use of local anesthesia to numb teeth and tissues, treatment of injured teeth with dental restoration (fillings), removal of one or more teeth, treatment of disease or injured oral tissues (hard and/or soft), treatment of malposed (crooked) teeth and/or oral development or growth abnormalities, replacement of missing teeth with dental prosthesis.

I understand, through discussions with the doctor the nature and purpose of these procedures. Alternate procedure or methods of treatment, if any, have also been explained to me, as have their advantages and disadvantages, the risks, consequences and probable effectiveness or each, as well as the prognosis if no treatment is provided. I understand that there is no guarantee that the dental procedures will be successful; however, the procedures are desired and intended to result in improved oral conditions.

I agree that verbal discussions with the doctor has outlined why the procedures are recommended, what alternative treatments are available, what risks, consequences, and complications may result from these procedures, and that all my questions have been answered satisfactorily.

I further understand that I am free to withdraw my consent to treatment at any time and that this consent will remain in effect until such time that I choose to terminate it.

_____	_____	_____
Patient's Name	Signature of Parent or Guardian	Date
_____	_____	
Patient's Name	Relationship to Patient/Patient's	

_____
Patient's Name

_____
Patient's Name

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES
("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

_____
Patient Name (Please Print)

_____
Patient Name (Please Print)

_____
Patient Name (Please Print)

_____
Patient Name (Please Print)

_____ _____
Patient Signature Date

Authority of Personal Representative to Sign for Patient (check one):

□ Parent □ Guardian □ Power of Attorney □ Other: _____

Please Note: It is your right to refuse to sign this Acknowledgement.

Please list the name and relationship of the individuals who may receive your child's health information to the extent necessary to help with your child's healthcare or with payment for your child's healthcare. This may be revoked by you at any time in writing.

Full Name: _____ Relationship: _____ Phone #: _____

Full Name: _____ Relationship: _____ Phone #: _____

Full Name: _____ Relationship: _____ Phone #: _____

Please list other ways of contact if needed:_____

Dental Office Use Only

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

__ An emergency prevented us from obtaining acknowledgement.
__ A communication barrier prevented us from obtaining acknowledgement.
__ The individual was unwilling to sign.
__ Other:_____

PHOTO/VIEDO CONSENT:

I hereby grant permission to **Cavity Commando's Dentistry for Kids**, to use my child/children photograph &/or video for promotional use. I also authorized the doctor to use photographs, radiographs, other diagnostic material and treatment records for the purpose of teaching, research and scientific publications.

Signature of Parent or Guardian: _____

Printed Name of Parent: _____

Printed Name of Child: _____

Printed Name of Child: _____

Printed Name of Child: _____

Printed Name of Child: _____

Date: _____

ADDITIONAL CONSENT FORM:

You as a parent/guardian can list two adults (over the age of 18) who can bring your child to their appointments and consent to any and all treatment needs they will need while in our office. When this adult accompanies any child to an appointment, they will be asked to show a legal form of ID and if they are not listed on this document in your child's chart, the child will not be seen and will be rescheduled.

We not only have strict policies in place at our office, but we also must follow strict privacy act laws and be HIPAA (Health Insurance Portability and Accountability Act of 1996) compliant in our practice. Please understand that we do not wish to cause any parent/guardian or child an inconvenience with these policies, but we are required to abide by them in operating our dental practice.

The following adults can accompany and consent to any and all treatment for my child:

1. _____ Relationship: _____Phone #:_____

2. _____ Relationship: _____Phone #:_____

I, _____, as parent/guardian consent to the above adults accompanying my child to their dental appointment and consenting to any and all treatment for the child. I further authorize the release of my child's health information to the above adults when said adults accompany my child to their dental appointments, whether regarding health information necessary to help with my child's healthcare and/or with payment of my child's healthcare.

Parent/Guardian Signature _____ Date _____

_____

Office use only:

I attempted to obtain the parent/patient's signature in acknowledgement on this document, but was unable to do so as documented below:

Date _____ Initials _____ Reason_____

Welcome to our office and thank you for allowing us to provide excellent dental care for your child/children. We value specific reservations for dental needs and we take pride on providing the best possible experience for you and your child. However, we believe that the best relationships are based on understanding, so we offer these clarifications of our office policies.

Appointment /Cancellation/ No-Show Policy

Due to high demand for pediatric dental appointments and frequent no-shows, we require you to confirm your appointments two business days before and to be aware of the time and date. We require 2 business days to cancel any appointments so that we can schedule other children in need. We do understand that emergencies arise out of your control; although this might happen we ask that you contact us immediately to cancel in a timely manner. If an appointment is not confirmed, it will be removed from our schedule. It is up to the parents' responsibility to assure we have all phone numbers and emails updated. If there are two missed appointments without proper notice within a 12 month period (or at our discretion), you may be discharged from our practice for non-compliance.

Financial Policy

Please be aware that the individual bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. Please understand that financial arrangements are made directly with you.

1. Co-pays, co-insurance, deductibles, and payment for dental services rendered are due at time of visit. Also, understand that all insurance policies are different and that you, (guardian/parent), is responsible for knowing your insurance and for all payments, deductibles, and rejected charges. We accept cash, personal checks, credit card, and Care Credit. A charge of $30 will be assessed on checks returned for any reason. If we receive a returned check, we will not be able to accept checks from you in the future.
2. Dental Insurance: We are dedicated to providing all our patients with the finest treatment available and base our treatment recommendations on what will be best for your child and not what your insurance company does or does not pay
3. Emergency Treatment: All emergency treatment must be paid in full at the time the service is rendered.
4. Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. Unpaid accounts will be considered delinquent after thirty (30) days and in default after forty-five (45) days, after which time interest will be at a rate of 1.5% per month on unpaid balances (annual percentage rate of 18% or the legal interest rate, whichever is lower). If we have to refer your account to a collections agency, you agree to pay all our incurred collection costs. If we have to refer collection of the balance to a lawyer, you agree to pay all our incurred lawyer's fees plus all court costs. In case of a suit, you agree the venue shall be in Cookeville, TN.

Signature:_____ Date:_____