Pediatric Dentistry of Chattanooga

150 Stuart Crossing • Cleveland, TN 37312 • 423-476-2160
5572 Little Debbie Pkwy, Ste 110 • Ooltewah, TN 37363 • 423-238-4090
50 Bragg Lane • Ringgold, GA 30736 • 706-406-2196

1 Tell Us About Your Child

Today's Date: _____

Child's Name _____
Last First MI

❑ Male ❑ Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: (____) _____ SS#: _____

Email Address _____

2 Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ❑ Yes ❑ No

Whom may we thank for referring you? _____

Has this child been to Pediatric Dentistry previously? ❑ Yes ❑ No

Other family members seen by us? _____

Previous/Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed

3 Mother's Information:

❑ Biological Mother ❑ Step Mother ❑ Guardian

Name: _____ Birthdate: _____

Home #: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Work #: _____

SS#: _____

Driver's License No. _____ Exp. _____

4 Father's Information:

❑ Biological Father ❑ Step Father ❑ Guardian

Name: _____ Birthdate: _____

Home #: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Work #: _____

SS#: _____

Driver's License No. _____ Exp. _____

5 Person(s) with Consent to Bring My Child to Appointments:

Name: _____ Relation: _____

Name: _____ Relation: _____

Emergency Contact

Name: _____ Relation: _____

Address: _____

Phone #: _____

6 Primary Dental Insurance

Insurance Co.Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ___/___/___ SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ❑ Yes ❑ No

7 Why did you bring the child to the dentist today?

_____

Has the child ever had any unhappy dental visits? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Child's Physician: _____

Phone #: _____

Date of last visit to physician: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's current health: ❑ Good ❑ Fair ❑ Poor

Please list all drugs that the child is currently taking:

_____

_____

Are your child's immunizations up to date? ❑ Yes ❑ No

_____

Does your child have any drug allergies? ❑ Yes ❑ No

If yes, please list _____

Is your child allergic to latex? (Balloons, Bandaids, Bananas) ❑ Yes ❑ No

Please list any previous hospitalizations/surgeries/serious illnesses:

_____

8 Does the child have any of the following habits?

Lip Sucking / Biting ❑ Yes ❑ No

Nail Biting ❑ Yes ❑ No

Grinds Teeth ❑ Yes ❑ No

Thumb / Finger Sucking ❑ Yes ❑ No

9 Has the child ever had any of the following medical problems?

- ❑ Abnormal Bleeding/Hemophilia
- ❑ Allergies
- ❑ Anemia
- ❑ Anaphalaxis
- ❑ Any Hosptial Stays/Operations
- ❑ Artificial Heart Valve/Joint
- ❑ Arthritis
- ❑ Asthma
- ❑ Autism
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Cerebral palsy
- ❑ Chemotherapy/Radiation
- ❑ Chicken pox
- ❑ Cleft lip/Palate
- ❑ Convulsions/Epilepsy/Seizures
- ❑ Cystic Fibrosis
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Down Syndrome
- ❑ Emotion, Mental, Nervous Disorder
- ❑ Frequent Nose Bleeds
- ❑ Handicaps/Disabilities
- ❑ Hearing Impairment
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis
- ❑ Herpes/Cold Sores
- ❑ High Blood Pressure
- ❑ HIV/AIDS
- ❑ Intellectual Disability
- ❑ Kidney/Liver Problems
- ❑ Leukemia
- ❑ Measles
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Pregnancy
- ❑ Premature Birth
- ❑ Renal Dialysis
- ❑ Rheumatic/Scarlet Fever
- ❑ Sickle Cell Disease
- ❑ Speech Difficulties
- ❑ Thyroid Disease
- ❑ Tuberculosis (TB)
- ❑ Vision Problems
- ❑ Any Syndromes

If any of the above are checked, please give a brief explanation:

_____

_____

_____

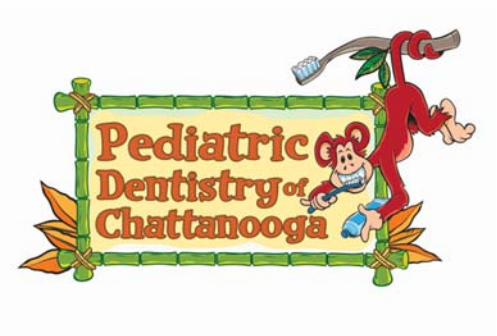
10 Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian

The parent or guardian who accompanies the child is responsible for payment of time of service unless prior arrangements have been approved.



Chad Eslinger, DDS **J Wayne Newman, DDS** **Jason Blair, DDS**
150 Stuart Crossing
Cleveland, TN 37312
Phone Number: (423) 476-2160 Fax: (423)-476-2680

Consent for Dental Treatment

Since _____is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all necessary dental services can be performed by Dr. Chad S. Eslinger, Dr. J Wayne Newman, Dr. Jason Blair and/or their Associates. Authorization is hereby granted as such. I understand that should there be a procedure that I do not wish to be performed on my child that I must notify the office prior to my child's visit. In order to provide the best care for your child routine cleanings include exam, prophy, fluoride and bitewing x-rays. Please note that no treatment will be done on your child without your prior consent.

Consent for Nitrous Oxide/Oxygen

(used on every patient during operative procedures)

Nitrous Oxide/oxygen is often used in the dental setting to help reduce anxiety. Risk of complications with nitrous oxide are rare, and its sedative effects are gone within five minutes after its use has been discontinued. The most common complications are nausea and vomiting.

I,_____, as the legally responsible parent/guardian of _____ give my consent to the use of nitrous oxide/oxygen that Drs.Eslinger, Dr.Newman or Dr. Blair deem necessary or advisable so as to enable them to render necessary dental treatment as indicated on the child's examination chart, as previously explained to me, and any procedure deemed necessary or advisable as a corollary to the planned treatment.

I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner.

Parent's Name: _____

Signature of Parent/Guardian:_____

Date: _____

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FINANCIAL POLICY

_____***1.Payment is due at the time services are provided***.
Our office accepts cash, checks, Mastercard and Visa. Our office does accept Care Credit (we only participate in their 6 months same as cash option.) **Future appointments will not be scheduled until your account is current.**

_____2. Our office does make an effort to obtain insurance benefit information; however, **we are not able to keep up with the specifics of each and every policy.** It is your responsibility to familiarize yourself with your personal policy; you may contact your insurance to find out specifics concerning coverage, insurance fee schedule and frequency limitations. If your policy requires preauthorization or has benefits limitations we need to be informed by you before treatment is rendered.

_____3. As a courtesy, we will file your primary insurance claim one time. You are ultimately responsible for the full amount charged for treatment; if insurance has not responded and paid claims within 90 days of service it is your responsibility to clear the account. Insurances failure to pay does not release you from your responsibility to pay.
We do not file secondary insurance.

_____4. All incurred charges are ultimately the responsibility of the patient, regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer and the insurance company. Our office is not a party to that contract or any possible restrictions.

_____5. **Each 6 month cleaning visit will include an exam, cleaning, and fluoride so that we may provide consistent and quality dental care for your child**. **We will do bitewing xrays one time a year unless your child has a history of decay between the teeth. Children with braces may be on a 3 or 4 month cleaning schedule, in these cases your child will not receive an exam every visit- they will have an exam two times a year, a cleaning and fluoride every visit.** Please contact your insurance if you have questions concerning yearly frequency limitations (ex. Some insurance companies only pay for fluoride once yearly). Please be advised if your insurance covers yearly cleanings, they will only pay at what they consider reasonable charges, meaning our fees maybe higher than what you insurance will pay. You will be responsible for any charges above what your insurance pays, and your balance will be due by the due date as stated on your invoice.

_____6. If operative treatment is required, we will provide you with a treatment estimate. Our **estimate of your co-pay, deductible and co-insurance is just that-- an estimate.** It is not a guarantee of coverage or payment from your insurance; you understand you will receive a bill for any remaining balance deemed your responsibility once insurance processes the claim.

_____7. Returned checks will be handled by an outside company called Nexcheck. Nexcheck will attempt multiple times to process your check through your bank account. Nexcheck will charge you a fee for handling your returned check.

_____8. **Patient balances not resolved in a timely manner will be sent to an outside collection agency at the patient's expense.** If your account is turned over for collection you are responsible for all collection agency fees, attorney fees, court costs, and all other costs of the collection

_____9. We will not get involved with divorce decree arrangements. Both parents are responsible for a minor child's bill and both parents will be held accountable. **Full payment is due from the person bringing the child at the time services are rendered**.

_____10. A consent form must be signed and on file if anyone other than the legal guardian will be bringing the child to their appointments. Please contact our office for payment estimation and send payment with the person bringing your child for service.

_____11. If a refund is due to you after insurance has paid, please contact our office to request the refund. We will not issue a refund until all claims for the account have been paid. Refunds are issued by our accountant every other week, so please allow 2 to 3 weeks to receive a refund check.

_____12. A **$35.00 charge** will be incurred for missed appointments and appointments cancelled without **twenty-four hour advance notice**. Families with an unreasonable amount of failed appointments can result in a dismissal from the practice.

I, the undersigned, have read the above policies and understand they apply to every patient at Pediatric Dentistry of Cleveland and Ooltewah.

_____ _____
Signature of Responsible Party Date