Dickson Pediatric Dentistry, PLLC.

Patient Registration

Welcome to our practice!

PATIENT INFORMATION

First Name		MI		Last Name		Birth Date	
Preferred Name		Age		Gender	❑ Male ❑ Female	Social Security #	
Address		City		State		ZIP	
Parent/Guardian Email							
How did you hear about us?							
Child's Physician						Phone #	
Emergency Contact *(other than parent)*							
First Name		Last Name				Cell Phone	

PARENT / GUARDIAN

❑ Mother ❑ Guardian				❑ Father ❑ Guardian			
First Name		M.I.		First Name		M.I.	
Last Name				Last Name			
Home Phone				Home Phone			
Work Phone				Work Phone			
Cell Phone				Cell Phone			
SSN				SSN			
Birth Date				Birth Date			
Employer				Employer			
Occupation				Occupation			
❑ Address Same as Patient				❑ Address Same as Patient			
Address				Address			
City				City			
State		ZIP		State		ZIP	
Marital Status	❑ Single ❑ Divorced ❑ Married ❑ Widowed ❑ Separated			Marital Status	❑ Single ❑ Divorced ❑ Married ❑ Widowed ❑ Separated		

LEGAL RESPONSIBLE PARTY

❑ Same as Mother/Guardian ❑ Same as Father/Guardian

First Name		MI		Last Name		Relationship	
Home Phone				Cell Phone		Work Phone	
Address				City		State	ZIP

First Name		Last Name	

HEALTH HISTORY

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Has your child ever had any of the following conditions?

	YES	NO		YES	NO		YES	NO
Asthma			Thyroid Problems			Anxiety		
Snores			Diabetes			Epilepsy		
Sleep Apnea			Acid Reflux			Seizures		
Cancer			Autism			Migraines		
Hepatitis			Developmental Delay			Heart Murmur		
Abnormal Bleeding			ADHD or ADD			Heart Defect		
Hemophilia			Disabilities			Rheumatic Fever		
HIV or AIDS			Other			If yes, please list		
Emergency Room Visit			If yes, what for?					
Previous Surgeries			If yes, what?					

MEDICATIONS

Please list all medications, over the counter & herbal supplements that the child is currently taking:

ALLERGIES

Is the child allergic to, or had any reaction to any of the following?

	YES	NO		YES	NO		YES	NO
Zithromax			Clindamycin			Cillins		
Sulfa Drugs			Latex			Nuts		
Red Dye								

Please list any allergy/ reaction to food, medications, or the environment that is not listed above:

CHILD HABITS

How often does your child brush?		How often does your child floss?	
Previous Dentist		Date of last dental visit	

Has your child had difficulty with previous visits?	❑ Yes	❑ No	❑ N/A
Is your child's water fluoridated?	❑ Yes	❑ No	❑ N/A
Does your child take fluoride supplements?	❑ Yes	❑ No	

Does your child do any of the following? *Please check all that apply.*

❑ Suck thumb, finger	❑ Suck or bite lips	❑ Bite or chew nails
❑ Chew hard objects	❑ Grind teeth	❑ Clench jaws

FORM COMPLETION

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Legal Guardian		Date	

Printed Name		Relationship	

Dickson Pediatric Dentistry, PLLC.

Office Policies & Consent Form

PATIENT INFORMATION

First Name		Last Name		Birth Date	

Thank you for choosing Dickson Pediatric Dentistry, PLLC as your child's dental care provider. Our dental health team is committed to excellence in dental care in a friendly, comfortable environment. It is very important to us as your dental care provider to utilize every means necessary to provide the best dental care possible and give your child a positive dental experience. Our doctors are uniquely trained to care for the oral health and dental development of infants, children, adolescents, and special needs patients. We ask that when you have an appointment, please call and confirm the appointment to ensure that we will still have availability. Unconfirmed appointments are not guaranteed and can be given away in the case of an emergency. However, confirmed or unconfirmed appointments can be counted against you if the appointment is not kept or if we are not notified within 24 hours of the appointment. After 3 missed appointments, you may be asked to find another provider.

By signing below, I hereby understand and authorize **Dr. John Stritikus, Dr. Justin Robbins, and their associate dentists** employed by Dickson Pediatric Dentistry to perform any and all necessary preventive and/or restorative procedures that they deem necessary, with the consent of the parent or legal guardian. These procedures may include, but are not limited to photographs, x-rays, fluoride treatments, fillings, extractions, crowns, the administering of nitrous oxide and/or sedation medications, and other dental procedures.

Insurance

Most procedures are covered by TennCare. Procedures not covered (or claims denied due to ineligibility) by TennCare have to be paid by the parents and/or guardians. It is your responsibility to make certain your TennCare coverage is in force before your appointment.

At DPD PLLC, we are not "in network" with all insurance companies. It is your responsibility to make certain your insurance plan will pay for your visit. Of course, we will be happy to assist you; however, please understand your insurance is contracted between you and the insurance company. We are the third party and have limited ability to act on your behalf. Upon signature of this policy & consent form, you authorize the practice to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and radiographs about the patient's medical history, services rendered, or recommended treatment. You also authorize the practice to submit claims for payment for services rendered or pre-authorizations necessary to your insurance company, on your behalf or the patient's behalf with your name listed as "signature on file" and assign to the practice the insurance benefits, providing assignment is accepted. You are responsible for payment regardless of the coverage provided. Any account not paid in full within 90 days will be subject to collection fees. The fees incurred will be the responsibility of the parents and/or guardians. These fees may include, but are not limited to, returned check fees, attorney fees, and court costs.

Clinical Consent

I authorize the practice to take radiographs, study models, photos, and other diagnostic aids or materials (collectively "diagnostic material") as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payors and/or other health professionals.

I authorize the practice to use my child's photos and/or x-rays for educational purposes and clinical presentations as the practice deems appropriate. The patient's confidential information will never be disclosed.

We are required to inform you that our office is equipped with a video surveillance camera system. This system was acquired to provide parents/guardians with the comfort and assurance of having the opportunity to observe their children during dental procedures.

FORM COMPLETION

I have read this form and agree to the terms and conditions herein.

Signature of Parent or Legal Guardian		Date	

Printed Name		Relationship to Patient	

Dickson Pediatric Dentistry, PLLC.

HIPAA Acknowledgment

PATIENT INFORMATION					
First Name		**Last Name**		**Birth Date**	

Acknowledgment of Receipt of Notice of Privacy Policies

Your Privacy Is Important To Us

Please click on the hyperlink to obtain a copy: *Notice of Privacy Practices*

I have been given the opportunity to view a copy of the Notice of Privacy Practices of Dickson Pediatric Dentistry, PLLC and I am aware that it is posted on site. I hereby authorize, as indicated by my signature below, to use and to disclose my protected health information for any necessary clinical, financial, and insurance purpose, as well as my dependent's, as authorized in the Patient Consent Form.

Authorization for Personal Health Information

Please list authorized person with whom we may discuss your Protected Health Information (PHI) in addition to custodial parents and legal guardians:

1. _____
   Printed Name — Relationship to Patient

2. _____
   Printed Name — Relationship to Patient

3. _____
   Printed Name — Relationship to Patient

4. _____
   Printed Name — Relationship to Patient

In my ABSENCE I hereby authorize the above person/people to accompany my child/children for necessary preventative and/or restorative appointments to Dickson Pediatric Dentistry, PLLC as deemed by Dr. John Stritikus, Dr. Justin Robbins, their associates and DPD PLLC staff. These procedures could include photographs, x-rays, fluoride treatments, nitrous oxide, possibly even sedation medications. As witnessed by my signature, I will indemnify and hold harmless Dr. John Stritikus, Dr. Justin Robbins, their associates and DPD PLLC staff, for all claims arising out of my consent for my child to be treated.

FORM COMPLETION			
Signature of Parent or Legal Guardian		**Date**	
Printed Name		**Relationship to Patient**	