PEDIATRIC DENTAL ASSOCIATES MORRISTOWN

Edward H. Moody, Jr., DDS

☎ (423) 587-1421
(423) 587-6092

3005 West Andrew Johnson Highway
Morristown, TN 37814
childrensdentistrymorristown.com

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CH ILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Full Name _____ Nickname _____ Age _____

Sex _____ Race _____ Date of Birth _____ Social Security # _____

Patient's address _____ Home Phone _____
Street City State Zip

School _____ E-mail _____

Father's Full Name _____ Social Security # _____

His Address _____ Phone _____
Street City State Zip

Date of Birth _____

Where Employed? _____ Phone _____

Mother's Full Name _____ Social Security # _____

Her Address _____ Phone _____
Street City State Zip

Date of Birth _____

Where Employed? _____ Phone _____

Phone Numbers for confirmation of appointment _____

With whom does patient live _____

Other children in family - names and ages _____

Dental Insurance? yes ___ no ___ Company _____ Policy Number _____

Company _____ Policy Number _____

Tenncare? yes ___ no ___ Number _____ Other funds _____

Child's Physician _____ Family Dentist _____

Whom may we thank for referring you to our office _____
(Doctor) or (Parent) or (Patient)

Address, if known _____
Street City State Zip

(OVER)

HEALTH HISTORY

	Yes	No	Don't Know
Is your child taking vitamins or flourides?	____	____	____
Do you have flouride in your water system? Water source: City ____ Spring ____ Well ____	____	____	____
Does your child have regular medical examinations?	____	____	____
Is your child in good health?	____	____	____
Is your child up to date with immunizations?	____	____	____
How often are the child's teeth brushed each day? _____ By whom? _____	____	____	____
Is this your child's first visit to the dentist?	____	____	____

Is your child a thumb/finger sucker? _____ Use a pacifier? _____

If your child was bottle fed, at what age was it discontinued? _____

Check any of the following that may pertain to your child:

__ Rheumatic fever	__ Bleeding disorder	__ Lung problem	__ Emotional disorder	__ AIDS
__ Heart condition	__ Cerebral palsy	__ Brain injury	__ Tuberculosis	__ Injury to teeth or mouth
__ Speech disorder	__ Liver	__ Epilepsy	__ Sickle Cell Anemia	__ Seizures
__ Hearing disorder	__ Kidney	__ Hepatitis	__ Autism	__ Pneumonia
__ Vision disorder	__ Asthma	__ Diabetes	__ Night grinding	__ Heart murmur
__ Nervous disorder	__ Allergies	__ Mental disorder	__ Transfusion	

If yes to any,

Explain _____

Is your child presently taking any medicine? _____ (Name of Medication)	____	____	____
Has your child experienced any unfavorable reaction to medicine?	____	____	____
(Such as penicillin, aspirin, xylocaine) List _____			
Is your child presently undergoing medical treatment?	____	____	____
Has your child ever been hospitalized since birth?	____	____	____
If so, Date: _____ Reason _____			
Has your child ever had an unfavorable experience in a dental office?	____	____	____
Date of your child's last dental care _____ Were x-rays taken?	____	____	____
Does your child have a toothache? _____			
Purpose of this appointment _____			

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment _____

Your child is a minor; therefore, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin.

I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs, I certify that I have legal authority to authorize such care. I understand that restraints may be used only when children may harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. If my child ever has a change in his/her health or his/her medications, I will inform the doctor at the next appointment without fail. I realize that the parent bringing the patient to the office is responsible for payment of the account and I will be responsible for the cost of this dental care. In the event of default, I agree to pay a reasonable collection and/or attorney fee.

Date _____ _____

Signuture of person completing form and responsible for payment of account

_____ Dental Assistant reviewing history

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient Name: _____

Address: _____

Telephone: _____ Email: _____

Section B: To the Patient/Parent - **Please read the following statements carefully:**

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain those changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time, by contacting the office at:

Telephone: 423-587-1421 Fax: 423-587-6092 Email: info@childrensdentistrymorristown.com
Address: 3005 West Andrew Johnson Highway Morristown, TN 37814

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact address listed above. Please understand the revocation of Consent will not affect any action we took in reliance on this Consent before receiving your revocation, and that we may decline to treat or continue treating you if you revoke this Consent.

Acknowledgement:

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature: _____ **Date:** _____

Relationship to Patient: _____

You are entitled to a copy of this consent after you sign it

Pediatric Dental Associates Morristown

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ have received a copy of this office's Notice of Privacy Practices.
Parent / Legal Guardian's Signature

_____ _____
Please Print Name of Parent / Legal Guardian Date

_____
Please Print Patient Name

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ Emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (please specify)

_____
_____
_____

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CONSENT TO ACCOMPANY A MINOR CHILD

Patient(s) Name: _____ Date(s) of Birth: _____

_____ _____

_____ _____

_____ _____

I, _____, give permission to _____

(Parent or Legal Guardian) (person(s) to accompany patient)

to accompany my child to Pediatric Dental Associates for dental appointments.

I also give permission to the person(s) named above to make any necessary decisions regarding dental treatment for my child including but not limited to:

the consent for this authorized person(s) to sign any and all forms required to give permission to Pediatric Dental Associates to treat the dental needs of my child on the day of service and to discuss the needs and sign any forms pertaining to the future dental treatment needs (ie: treatment plans, consent forms, health history forms) of my child.

the consent for this authorized person(s) to discuss treatment recommended, go over my child's dental needs and preventative care and post op instruction and details on procedures with the Doctors, Clinical Staff, or Administration Staff for my child.

the consent to the dental practice to discuss any account information and finances (details on account, treatment charges, account balances, next visit charges, insurance information) with this authorized person(s) and for this person to schedule any future dental visits for my child.

I understand this consent will be valid for one year or until I rescind this agreement in writing.

Signature of Parent / Legal Guardian: _____ Date: _____

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Authorization for Use or Disclosure of Patient Photographic and/or Video Images

I authorize the use and disclosure of my minor child's photographic/video images and/or testimonials for marketing purposes (social media, website, and/or advertising) by **Pediatric Dental Associates Morristown**. I understand that information disclosed pursuant to this authorization may no longer be protected by HIPPA privacy regulations; however, all other dental health information is protected.

I have been informed that I am not required to sign this consent and that the practice cannot condition treatment on whether or not I sign it. I also understand I am not financially compensated for this authorization. I further acknowledge that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization does not have an expiration date.

Patient's Name _____ Date of Birth _____

Parent / Guardian Signature _____

Date _____