Patient Health History

Patient's name _____

Does your child have regular medical exams? _____ Are your child's immunizations up to date? _____

If not, please explain_____

Is your child taking any medications? _____ If so, please list them _____

_____

Has your child ever experienced an unfavorable reaction to a medication/drug (drug allergy)? _____If yes, please list the medications and the type of reaction _____

Does your child have any other allergies (seasonal, food, etc)? _____

If yes, please explain _____

Does your child have a latex allergy? _____ If yes, please explain the reaction _____

Is your child currently undergoing medical treatment or have they undergone medical treatment in the past? _____

If yes, please explain _____

_____

Has your child ever been hospitalized? _____ If yes, please explain and include the date of hospitalization

_____

_____

Has the patient travelled outside the country in the past 6 months? _____ If yes, where? _____

Please mark any conditions that apply to your child

☐ Rheumatic fever	☐ Heart condition	☐ Heart murmur
☐ Speech disorder	☐ Delayed development	☐ HIV/AIDS
☐ Hearing disorder	☐ Mental disorder	☐ Pregnancy
☐ Vision disorder	☐ Emotional disorder	☐ Head Lice
☐ Nerve disorder	☐ Autism	☐ ADD/ADHD
☐ Bleeding disorder	☐ Poison ivy/oak	☐ Chicken Pox
☐ Kidney problems	☐ Ringworm	☐ Cerebral Palsy
☐ Gag reflex	☐ Tuberculosis	☐ Down's Syndrome
☐ Asthma	☐ Sickle Cell Anemia/Trait	☐ Other
☐ Brain injury	☐ Diabetes	
☐ Epilepsy	☐ Hepatitis	

If you marked any of the above conditions, please explain _____

_____

Dental

Is this your child's first dental visit? _____ If no, when was their last visit? _____

Has your child had an unfavorable experience at a dental office? _____

If yes, please explain _____

Does your child have a toothache? _____

Does your child have any oral habits (thumbsucking, nail biting, grinding, etc)? _____

If yes, please explain _____

Does your child have a pacifier habit? _____Does your child use a sippy-cup? _____ Do they take it bed? _____

Is your child still bottle or breast-feeding? _____ _____ At night? _____

Guardian Signature _____ **Date** _____

PATIENT NAME_____

Patient Information

Patient's Information

First Name_____ Last Name_____ Goes by_____
Date of Birth_____ Sex_____ Social Security Number_____
Home Address_____ City_____ Zip_____

Father's Information

First Name _____ Last Name_____ Date of Birth_____
[ ] Check if address is same as patient
Home Address_____ City_____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Email_____Employer_____
Social Security Number _____

Mother's Information

First Name_____ Last Name_____ Date of Birth_____
[ ] Check if address is same as patient
Home Address_____ City_____ Zip_____
Home Phone_____ Cell Phone_____ Work Phone_____
Email_____Employer_____
Social Security Number _____

Social History

Who does the patient live with? _____
Please list other children in the family _____

Pediatrician Information

Name_____ Phone number_____
May we have permission to consult them about your child prior to dental treatment if needed? _____

Dental Insurance

Who is the subscriber for this insurance? _____
Insurance company_____ Employer _____
Group Number_____ Subscriber ID_____

How Would You Like Us to Communicate with You?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you (check all that apply):

[ ] Phone [ ] Text Message [ ] Email

Referral

Who can we thank for referring you to our office? _____

Guardian signature_____ **Date**_____

Notices and Disclosures

Notice of Privacy Practices

By signing below, I verify that I have been made available a copy, either hard or electronic (through email or by visiting www.smpdtn.com for a copy), of Smoky Mountain Pediatric Dentistry's Notice of Privacy Practices. I understand that I may obtain a hard or electronic copy of the Notice of Privacy Practices for Smoky Mountain Pediatric Dentistry at any time by contacting us at 865-766-4884 or info@smpdtn.com. I understand I will be notified by email or standard mail if Smoky Mountain Pediatric Dentistry revises their Notice of Privacy Practices and receive either a hard or electronic copy of these revisions.

Guardian Signature _____**Date** _____

Authorized Benefits

I authorize and request my child's insurance company to pay directly to the dentist and Smoky Mountain Pediatric Dentistry those insurance benefits otherwise payable to me.

Financial Account Agreement

I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of my dependents. I understand payment in full is expected at the beginning of each appointment if there is no insurance or if the full fee is not covered by my insurance.

Account Default

I understand that failure to keep my financial account with Smoky Mountain Pediatric Dentistry current may result in Smoky Mountain Pediatric Dentistry not being able to provide dental services, except where there is pre-payment for additional services. I understand in the case of default on payment to my child's account, I agree to pay collection costs and reasonable attorney fees in attempting to collect on this account or any future account balances.

Guardian Signature _____**Date** _____

Consent for Use and Disclosure of Health Information

I authorize the dentist to release my child's information including the diagnosis and records of any treatment or exams rendered to my child to third party payers and health care practitioners.

I understand I have the right to revoke this consent at any time by submitting written notice to Smoky Mountain Pediatric Dentistry at info@smpdtn.com or 550 Town Creek Rd East Suite 101 Lenoir City, TN 37772. I understand that revocation of this consent will not affect any action we took in reliance of this consent before we received your revocation and that Smoky Mountain Pediatric Dentistry may decline to treat your child if you revoke this consent.

Guardian Signature _____**Date** _____

Photo Consent Form

I give Smoky Mountain Pediatric Dentistry and any of its employees and/or agents the right and permission to use and/or publish photographs of my child for art, promotional and educational purposes (including but not limited to, advertising, publicity, social media, commercial use or display).

Guardian Signature _____**Date** _____

PATIENT NAME_____

Authorized Adult Consent

I authorize the following adults (18 and older) to bring my child to future dental appointments.

1. _____
2. _____
3. _____
4. _____

I authorize the following adults (18 and older) to consent to dental treatment for my child when I am not present.

1. _____
2. _____
3. _____
4. _____

Guardian Signature _____ **Date** _____

PATIENT NAME_____

Office Policies

1. Only one adult is allowed to accompany your child to the operatory for treatment (this excludes new patient exam)
2. Under no circumstances will siblings, younger or older, be permitted in the operatory during your child's treatment (excludes exams) nor will they be allowed to be left in the waiting area without adult supervision.
3. Your child will not be seen unless signed in by an authorized adult (18 or older). Under no circumstance is that adult allowed to leave the office and/or its premises while your child is undergoing treatment.
4. If someone other than the legal guardian accompanies your child to their dental appointments, they must be listed on the authorized adults consent form.
5. Appointments that need to be cancelled must be done with at least a 24 hour notice. If they are cancelled with less than a 24 hour notice, it could result in a broken/missed appointment charge (on a case by case basis).
6. Three (3) or more cancellations with less than a 24 hour notice or more than three (3) broken/missed appointments per family in a 12 month period will result in your child/children not being seen by our office in the future.
7. If you are more than 10 minutes late for an appointment, you may be asked to reschedule your child's appointment and a broken/missed appointment charge will be given.
8. Cell phone usage for conversations past the waiting room is not permitted as this is a distraction to the doctor/doctor's assistants as they try to provide the best care for your child. If you use your cell phone for texting or to play games/use the internet, you must turn the volume off.
9. You are responsible for confirming your child's appointment at least 48 business hours prior to their appointment. We send confirmation texts, emails, and calls starting 1 week before the appointment. Failure to confirm within 48 business hours will result in your child's appointment being given to another patient.
10. Our office only treats children who are up to date on their immunizations.

I have read and agree to all policies for Smoky Mountain Pediatric Dentistry.

Guardian Signature _____ **Date** _____

PATIENT NAME_____