Dr. Margaret Moore, DMD Dr. Megan Flournoy, DMD
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(478) 333-3636 (phone)

PLEASE FILL OUT ONE FORM (FRONT AND BACK) PER FAMILY
We are so pleased to welcome you and your child to our practice. We look forward to working with you in maintaining your child's dental health!

Child(ren) _____

_____

Address _____

Mom Cell _____ Dad Cell _____ Home Phone _____

Email _____

Whom may we thank for referring you to our practice? _____

PARENT/GUARDIAN INFORMATION

Biological/Adoptive Mother/Guardian _____ Date of Birth _____
Biological/Adoptive Father/Guardian _____ Date of Birth _____
Step Mother _____ Date of Birth _____
Step Father _____ Date of Birth _____

Who does the child live with? _____

Is either parent active military? ☐Yes ☐No
Are the child's biological or adoptive parents married? ☐Yes ☐No
Are the child's biological or adoptive parents divorced? ☐Yes ☐No

Is there a divorce decree or custody order that states who must carry health insurance for the child(ren)? ☐Yes ☐No
*If there is a decree or order, we will need a copy of the relevant portion (not the entire order) stating who must hold insurance.

PRIMARY INSURANCE INFORMATION

Policy Holder _____ Policy Holder SS# _____
Insurance Company _____ Ins. Co. Phone # _____
Policy # _____ Group # _____
Employer _____

SECONDARY INSURANCE INFORMATION

Policy Holder _____ Policy Holder SS# _____
Insurance Company _____ Ins. Co. Phone # _____
Policy # _____ Group # _____
Employer _____

CONSENT FOR TREATMENT

I am the parent or legal guardian of the minor child or children listed with this packet and there are no court orders now in effect that prevent me from signing this consent. The information I have given is correct to the best of my knowledge. I fully understand that Pediatric Dentistry of Central Georgia, PC is relying on the information I have provided in agreeing to treat my child. It will be held in the strictest confidence and it is my responsibility to inform Pediatric Dentistry of Central Georgia PC, of any changes in my child's medical status. I authorize Dr. Moore, Dr. Flournoy and/or associates to perform any necessary dental procedures. **ALL PROCEDURES WILL BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT AND A TREATMENT PLAN SIGNED**.

Parent/Guardian: _____ Date: _____

Print Name: _____

FINANCIAL INFORMATION

Our policy requires payment in full at the time of service. For those families utilizing insurance benefits, we are happy to file your insurance claim as a courtesy. However, there is no direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer, determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement or the determination of your insurance benefits. Reimbursement for covered services is subject to maximum allowable fees, deductibles, and co-payments. Your responsibility is ***estimated*** and ***due at the time of treatment***. It is also your responsibility as parent/guardian to pay any remaining balance on your account after any and all insurance benefits have been collected. I hereby authorize all insurance benefits, if any, to be assigned directly to Pediatric Dentistry of Central Georgia, otherwise payable to me for services rendered. I authorize the release of any information to process insurance claims, including the use of my signature on all insurance submissions. If your account is not paid within 75 days, you will be liable for all collection fees, interest charges, and any other expenses incurred while collecting your account. There is a fee of $50 for returned checks.

Parent/Guardian: _____ Date: _____

Print Name: _____

CONFIRMATION & MISSED APPOINTMENT POLICY

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and ***INDIVIDUAL*** attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time during our busy schedule, we must ask that parents arrive on time for their children's appointments. This allows us to be able to see all the children that are scheduled in a timely and efficient way. When a parent is *late* or *fails* to make a scheduled appointment, this may jeopardize all the children's treatment. It also affects other parent's schedules that have children scheduled after your child that day.

- Parents may change or cancel their child's appointment with at least a 48-hour notice (2 business days).
- Appointments must be confirmed *48 hours in advance.* If you do not confirm the appointment then it will be moved off the schedule. Pediatric Dentistry of Central Georgia, PC will place a courtesy call prior to your appointment to answer any questions you may have.
- If a patient is more than 15 minutes late, we may need to reschedule the appointment. If we are able to see the child, we cannot guarantee that all treatment will be completed.
- There may be a $50 fee charged to your account for all appointments that are cancelled and/or broken within less than 24 hours. If your child is being sedated and you do not give 48hrs notice (2 business days) you will forfeit your deposit.
- After having 2 missed or broken appointments, we will no longer be able to provide your child dental care. If this happens, you will be notified by mail of your child's dismissal for the practice. We will continue to provide emergency dental care for your child for up to 30 days following the dismissal.

Parent/Guardian: _____ Date: _____

PLEASE FILL OUT ONE FORM (FRONT AND BACK) FOR EACH CHILD.

Name _____

Date of Birth _____ ☐Male ☐Female Hobbies _____

DENTAL HISTORY

Last Dental Visit: _____ Last Cleaning: _____ Last X-Rays: _____

Previous Dentist _____ Do you have a copy of x-rays? _____

My child brushes his/her teeth _____ times per day.

Do you help your child brush his/her teeth? ☐Always ☐Sometimes ☐Never

Does your child have any mouth habits? (Please circle all that apply)

Thumb/Finger Sucking Grinding during sleep Sleeping with bottle Pacifier

Other: _____

Does your child floss every day? ☐Yes ☐No
Is fluoride taken in any form? ☐Yes ☐No
Do you expect your child to be cooperative? ☐Yes ☐No
Does your child do well at hair appointments? ☐Yes ☐No

Any injuries to the mouth/teeth? ☐Yes ☐No Please explain: _____

Is there a history of bad dental experience? ☐Yes ☐No Please explain: _____

Is your child in pain today? ☐Yes ☐No Please explain: _____

Does your child have a dental condition about which you are especially concerned? _____

Child's Pediatrician _____ City/State _____

Pediatrician Phone # _____ Date of last exam: _____

Has he/she ever been hospitalized or had surgery? ☐Yes ☐No Why? _____

Any handicaps/disabilities? ☐Yes ☐No List: _____

MEDICAL HISTORY Child's Name _____ Weight _____

Place a mark on yes or no for each of the following.

ADD/ADHD	☐Yes	☐No	Drug/Alcohol Abuse	☐Yes	☐No	Reflux	☐Yes	☐No
AIDS/HIV	☐Yes	☐No	Epilepsy	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Anemia	☐Yes	☐No	Fainting	☐Yes	☐No	Sensory Process Disorder	☐Yes	☐No
Asperger's	☐Yes	☐No	Headaches	☐Yes	☐No	Scarlet Fever	☐Yes	☐No
Asthma	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Sickle Cell	☐Yes	☐No
Autism	☐Yes	☐No	Heart Valve Replacement	☐Yes	☐No	Sinus Problems	☐Yes	☐No
Bladder Issues	☐Yes	☐No	Hepatitis	☐Yes	☐No	Skin Disorder	☐Yes	☐No
Bleeding Issues	☐Yes	☐No	Hemophilia	☐Yes	☐No	Speech Problem	☐Yes	☐No
Cancer/Tumors	☐Yes	☐No	Kidney/Stomach Disease	☐Yes	☐No	Thyroid Disease	☐Yes	☐No
Cerebral Palsy	☐Yes	☐No	Learning Disabilities	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Cleft Palate	☐Yes	☐No	Lung Disease	☐Yes	☐No	Other:		
Hearing Loss	☐Yes	☐No	Measles	☐Yes	☐No	_____		
Chicken Pox	☐Yes	☐No	Mumps	☐Yes	☐No	Are you on well water?	☐Yes	☐No
Diabetes	☐Yes	☐No	Radiation/Chemotherapy	☐Yes	☐No	**Girls:** Are you pregnant?	☐Yes	☐No

If you said yes for the following, please provide additional information:

Asthma When was your child's last attack? _____

Has he/she ever been hospitalized for asthma? ☐Yes ☐No If so, when? _____

Epilepsy When was your child's last seizure? _____

Has he/she ever been hospitalized for epilepsy? ☐Yes ☐No If so, when? _____

Any additional health concerns? _____

MEDICATIONS List any medications that your child is currently taking and the correlating diagnosis: _____

_____

ALLERGIES ☐ NONE ☐ Penicillin/Amoxicillin ☐ Latex ☐ Aspirin ☐ Sulfa

☐ Metal ☐ Local Anesthetic ☐ Other (List) _____

UPDATE: _____ (signature) _____ (date) _____ (current weight)

UPDATE: _____ (signature) _____ (date) _____ (current weight)

UPDATE: _____ (signature) _____ (date) _____ (current weight)

UPDATE: _____ (signature) _____ (date) _____ (current weight)

UPDATE: _____ (signature) _____ (date) _____ (current weight)