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We are so pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you. We look forward to working with you in maintaining your child's dental health!

PATIENT INFORMATION

Child's Name: _____
LAST FIRST MIDDLE NICKNAME

☐ Male ☐ Female Date of Birth: ___/_____/_____ Social Security # _____

Hobbies: _____

Address: _____
STREET APT# CITY STATE ZIP

Home Phone#: _____ Mom's Cell#: _____ Dad's Cell#: _____

Email Address: _____

How would you prefer us to contact you regarding notice of upcoming appointments?

☐ Email ☐ Text ☐ Cell ☐ Home Phone

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

PARENT'S INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian Name: _____

Address: (if different from above): _____

Home # (if different from above): _____ Work # _____ ext ____ Employer: _____

Social Security # _____ DOB _____

☐ Father ☐ Stepfather ☐ Guardian Name: _____

Address: (if different from above): _____

Home # (if different from above): _____ Work # _____ ext ____ Employer: _____

Social Security # _____ DOB _____

PRIMARY INSURANCE INFORMATION

Policy Holder:_____ Relationship to patient:_____

Policy Holder's Social Security#: _____ Date of Birth:_____/_____/____

Insurance Company:_____ Employer: _____

Policy #_____ Group#_____ Telephone # of Ins Company_____

SECONDARY INSURANCE INFORMATION

Policy Holder:_____ Relationship to patient:_____

Policy Holder's Social Security#: _____ Date of Birth:_____/_____/____

Insurance Company:_____ Employer: _____

Policy #_____ Group#_____ Telephone # of Ins Company_____

DENTAL HISTORY

Last dental visit: _____/_____/_____ *Last Cleaning:*_____/_____/_____ *Last* X-rays:_____/_____/_____

Previous Dentist:_____ Do you have a copy of previous X-rays? ❑ Yes ❑ No

My child brushes his/her teeth ____times a day.

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

Does your child floss every day? ❑ Yes ❑ No

Is there a history of bad dental experiences? ❑ Yes ❑ No

Please explain_____

Do you expect your child to be cooperative? ❑ Yes ❑ No

Is your child in pain today? ❑ Yes ❑ No

Please explain_____

Is fluoride taken in any form? ❑ Yes ❑ No

Any injuries to mouth/teeth? ❑ Yes ❑ No

Are you on well water? ❑ Yes ❑ No

Does your child do well at hair appts.? ❑ Yes ❑ No

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

Thumb/Finger Sucking Grinding during sleep Pacifier Sleeping with bottle Other_____

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

_____

MEDICAL HISTORY

Child's Name: _____

Child's Pediatrician: _____ City/State: _____ Phone: _____

Date of last physical exam: ____/____/____

Has he/she ever been hospitalized or had surgery? ❑ Yes ❑ No If so, why?: _____

Any handicaps/disabilities? ❑ Yes ❑ No Please List: _____

Place a mark on "yes" or "no" if your child has had any of the following:

ADD/ADHD	❑ Yes ❑ No	Drug/Alcohol Abuse	❑ Yes ❑ No	Radiation/Chemotherapy	❑ Yes ❑ No
AIDS/HIV	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No	Reflux	❑ Yes ❑ No
Anemia	❑ Yes ❑ No	Fainting	❑ Yes ❑ No	Rheumatic Fever	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Headaches	❑ Yes ❑ No	Scarlet Fever	❑ Yes ❑ No
Autism	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No	Sickle Cell	❑ Yes ❑ No
Bladder Issues	❑ Yes ❑ No	Heart Valve Replacement	❑ Yes ❑ No	Sinus Problems	❑ Yes ❑ No
Bleeding Issues	❑ Yes ❑ No	Hepatitis	❑ Yes ❑ No	Skin Disorder	❑ Yes ❑ No
Cancer/Tumors	❑ Yes ❑ No	Hemophilia	❑ Yes ❑ No	Speech Problem	❑ Yes ❑ No
Cerebral Palsy	❑ Yes ❑ No	Kidney/Stomach Disease	❑ Yes ❑ No	Thyroid Disease	❑ Yes ❑ No
Cleft Palate	❑ Yes ❑ No	Learning Disabilities	❑ Yes ❑ No	Tuberculosis	❑ Yes ❑ No
Hearing Loss	❑ Yes ❑ No	Lung Disease	❑ Yes ❑ No	Other: _____	
Chicken Pox	❑ Yes ❑ No	Measles	❑ Yes ❑ No	_____	
Diabetes	❑ Yes ❑ No	Mumps	❑ Yes ❑ No	_____	

Girls: Are you pregnant? ❑ Yes ❑ No Are you on well water? ❑ Yes ❑ No

If you said yes for the following:

Asthma when was your child's last attack?_____ Has he/she ever been hospitalized for asthma?_____ If so when?_____

Epilepsy when was your child's last seizure?_____ Has he/she ever been hospitalized for epilepsy?_____ If so when?_____

Any additional health concerns?_____

_____

MEDICATIONS

Please list any medications that your child is currently taking and the correlating diagnosis: _____

_____

ALLERGIES

❑ None ❑ Penicillin/Amoxicillin ❑ Latex ❑ Aspirin ❑ Sulfa ❑ Local Anesthetic

❑ Metal ❑ Other (Please list):_____

Update:_____ _____
signature date

Update:_____ _____
signature date

Update:_____ _____
signature date

Update:_____ _____
signature date

Update:_____ _____
signature date

CONSENT FOR TREATMENT

The information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform Columbus Children's Dentistry, PC, of any changes in my child's medical status. I authorize Dr. Keller and/or associates to perform the following necessary dental procedures including, but not limited to, the use of Nitrous Oxide (laughing gas), local anesthetic (like Lidocaine), dental cleanings, fluoride applications, and any necessary x-rays needed on my child.

ALL PROCEDURES WILL BE DISCUSSED WITH YOU PRIOR TO ANY DENTAL TREATMENT AND A TREATMENT PLAN SIGNED.

Parent/Guardian:_____ Date:_____

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 have been collected.

If your account is not paid within 90 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.

I hereby authorize all insurance benefits, if any, to be assigned directly to Columbus Children's Dentistry, 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.

Parent/Guardian:_____ Date._____

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 24 hour s notice (1 business day).
- 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 $45 fee charged to your account for all appointments that are canceled and/or broken within less than 24 hours. If your child is being sedated and you do not give 48 hours 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.

Appointments must be confirmed 24 hours in advance. If you do not confirm the appointment then it will be moved off the schedule. Columbus Children's Dentistry will place a courtesy call prior to your appointment to answer any questions you may have. Please call 706-225-0444 any time you have concerns about your child's dental health. Feel free to leave a message on the machine.

Parent/Guardian:_____ Date:_____

COLUMBUS CHILDREN'S DENTISTRY