# Welcome!

We would like to welcome you and your child to our office. Our goal is to make every child's visit **pleasant and educational.** Our practice is based on **preventative care.** We strive to teach good oral care that will enable your child to have a **beautiful smile that lasts a lifetime.**

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.**

## 1 ABOUT YOUR CHILD

Name: _____

Name child goes by: _____

Birthdate: _____ Male ☐ Female ☐

Child's home address: _____

_____

City State Zip

Child's Soc. Sec. #: _____

Home phone: _____

Phone # to confirm appt. _____

Cell phone: _____

_____

Brothers and Sisters who receive care in our office:

_____

Who referred you so we can thank them?

_____

## 2 ABOUT YOU

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐Yes ☐ No

Does the Child Have Tenn Care? ☐Yes ☐ No

Do we need an interpreter? ☐Yes ☐ No

In the event of an emergency, who should we contact?

Name: _____

Relationship: _____

Phone #1: _____

Phone #2: _____

## 3 PARENT'S INFORMATION

Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Father ☐ Step Father ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's)

_____

_____

SS #: _____ DL #: _____

Wk #:(____)_____ Ext:_____ Hm #:(____)_____

Email: _____ Cell/Other #: (___)_____

Employer: _____

Employer's Address: _____

_____

City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name _____

Insurance Address: _____

_____

City State Zip

Insurance Phone(____) _____

Group # : _____

☐ Mother ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's)

_____

_____

SS #: _____ DL #: _____

Wk #:(____)_____ Ext:_____ Hm #:(____)_____

Email: _____ Cell/Other #: (___)_____

Employer: _____

Employer's Address: _____

_____

City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name _____

Insurance Address: _____

_____

City State Zip

Insurance Phone(____) _____

Group # : _____

Statement of Support form must be updated every 12 months. Has there been a court decree issued regarding patient's dental insurance coverage? ☐ Yes ☐ No
If yes additional paperwork must be completed before the child's first appointment.

# DENTAL/MEDICAL HISTORY

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Has your child been to the dentist before? ☐ Yes ☐ No
If yes, the approximate date of last visit: _____
Were X-rays taken? ☐ Yes ☐ No
Are there any dental problems that you are aware of at present? ☐ Yes ☐ No If yes, please explain: _____
_____
Does your child brush his/her teeth daily? ☐ Yes ☐ No
Please rate your child's oral health. ☐ Good ☐ Fair ☐ Poor
Does the child have any of the following habits? ☐ Grinding Teeth ☐ Mouth Breathing ☐ Speech Problems ☐ Thumb sucking ☐ Pacifier ☐ Other _____
Did your child take a bottle to bed? ☐ Yes ☐ No
Does your child use a "Sippy" cup? ☐ Yes ☐ No
What is in it? _____
When is it taken? _____
Does your child drink fluoridated water? ☐ City Water ☐ Spring / Well Water ☐ Bottled Water
Is your child currently under the care of a physician? ☐ Yes ☐ No
Child's physician: _____
Their phone #: _____
The approximate date of last visit: _____
Please rate your child's medical health. ☐ Good ☐ Fair ☐ Poor
**Is your child allergic to any drugs? ☐ Yes ☐ No**
If yes, please list: _____
Is your child taking any prescription drugs? ☐ Yes ☐ No
If yes, please list: _____
**Does your child need to be premedicated due to a medical condition before dental treatment? ☐ Yes ☐ No**

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## Has your child ever had any of the following medical conditions or problems?

| | Please circle | |
|---|---|---|
| Hepatitis | Y | N |
| Rheumatic Fever | Y | N |
| Heart trouble/Mitral Valve Prolapse | Y | N |
| Asthma | Y | N |
| Diabetes | Y | N |
| Kidney or Liver Involvement | Y | N |
| Epilepsy or Convulsions | Y | N |
| Hearing Impairment | Y | N |
| Sight Impairment | Y | N |
| Endocrine Problems | Y | N |
| Brain damage | Y | N |
| Food Allergy or Reaction | Y | N |
| Congenital Birth Defects | Y | N |
| History of Seizures | Y | N |
| Behavioral or Learning Problems | Y | N |
| ADD, ADHD, Autism (circle) | | |
| Other_____ | | |
| Recurrent Headaches | Y | N |
| Excessive Bleeding | Y | N |
| Ever had a Blood Transfusion | Y | N |
| Cancer, Tumor, Blood Dyscrasia | Y | N |
| Any Operations | Y | N |
| Please list any operations | | |
| _____ | | |
| Any Stays in the Hospital | Y | N |
| Skin lesions/TB | Y | N |

Are there any other medical conditions or problems relating to your child? ☐ Yes ☐ No
If yes, Please list: _____
Has your child experienced any unfavorable reaction from any previous medical or dental care? ☐ Yes ☐ No
Do you want your child to have complete dental care? ☐ Yes ☐ No

I understand that the information that 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 also will be careful in my words explaining the dental visit. I will try not to use such words as "shot," "hurt", "numb" etc.

**PERMISSION**

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any / or all necessary dental service can be performed by Dr. Aleighia B. Helderman. Authorization is hereby granted as such. Furthermore, I will be responsible financially for any bill incurred on this patient for dental treatment. Parent that brings child to office is legally responsible to us for payment of account.

Signed _____ Date _____

Relationship to child _____

Thank you for filling out this form completely. It will enable us to give your child The best dental care possible. If you have any questions please ask us at any time.

**Patient Name:** _____

## *Welcome!*

We are honored that you have chosen our office as your child's dental provider. We are constantly staying up on the leading technology and re-investing in our practice so we can deliver top notch, gentle, compassionate care. As our patient, our doctors and team will diagnose and treat with the fullest intent of the absolute best and gentle care possible. At no time will we diagnose or treat our patients by limiting ourselves under the guidelines of the insurance coverage. That being said, we will strive to get the maximum insurance payment for you when treatment is needed.

- **X-Rays**

Our office is equipped with safe digital dental radiographs. We will need current x-rays including *Panorex* (that are less than 3 years old) and *Bitewings* (less than 1 year old) and in digital format. It is the guardian's responsibility to make sure we have any x-rays from previous dental providers before your first appointment. Please be sure to call your previous dental care provider or other providers that may have any x-rays and have them sent to us. Dental x-rays are vital for our doctors to do a complete exam and provide quality care. If we do not have current x-rays in time for your appointment, we will take them in our office in order to have a complete exam. Insurance may or may not pay for these. ***Our standard of care in this practice is for cavity detection x-rays each year and a Panorex (head and neck) x-ray every 3 years. We do not allow your insurance policy to dictate the care that you deserve and the care that we provide.***

- **Medicine**

If your child needs to pre-medicate for any medical reason, please let us know in advance of your appointment. We can kindly remind you to issue their pre-medication prior to your child's scheduled appointment time. However, it is ***your*** responsibility to make sure your child has pre-medicated. If you arrive at your child's appointment and are not pre-medicated, and the doctor is unable to complete your appointment, you may be charged an office visit. It is very important we have a list of all the medicines that your child is currently taking.

- **Appointments**

Your child's scheduled appointment time has been reserved specifically for their care. **However, if you arrive 10 minutes past your scheduled appointment time, you may be asked to reschedule. We request 24-hour notice if you need to cancel any appointment. If you fail to make the appointment or do not give us a 24-hour cancellation notice, you may be charged a missed appointment fee.** We are aware that unforeseen events sometimes require missing an appointment. Recurrent broken or failed appointments may result in dismissing services as your child's provider. **ONE parent/guardian is allowed in the clinical area per child. Exceptions would be for sedation appointments, infant frenectomies, or other surgical procedures.**

- **Insurance**

**All insurance policies vary, and we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts.** It is your responsibility to know and understand your family's insurance plan(s) benefits. We will file your insurance because we want you to use the insurance that your company provided you with. **If you need to know exactly what is covered and what is not, you will need to call your insurance company.** We are a contracted provider for certain plans however, we will file all insurance claims because we value your business. It is impossible to research all the details of all these plans because they are **constantly changing.** Please do your diligence.

- **Payment**

**Your estimated balance is to be paid at the time of service.** As a service to our patients, we will bill insurance companies for services provided and allow them 30 days to render payment. After 30 days, you are responsible for the entire balance, paid-in-full. At that time, a finance charge will start to accrue each month on any past due balance. If you have any questions, our courteous staff are always available to answer them. If special financial arrangements are needed, an extended payment plan is available through Care Credit. We offer zero interest plans through Care Credit for up to 12 months. For more information about this plan please call the office or visit www.carecredit.com

If you have read and understand our new patient paperwork and expectations for how we want to care for your child, please sign and date this page. Again, thank you for allowing us to take care of your child's dental needs. Feel free to call our office with any questions or concerns.

_____ _____

{Parent/Guardian Signature} {Guardian's Name Printed}

_____

{Date}

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient(s) Name(s): _____

I, _____ authorize the doctor(s) and employees to do the following:

*Please Circle whether we MAY or MAY NOT do the following: *
They MAY/MAY NOT leave a message at my home/cell number.
They MAY/MAY NOT call me at work and leave a message.
They MAY/MAY NOT speak to my insurance company and receive information from them. (File Claims)
They MAY/MAY NOT post my child's photo (with prior consent) to Social Media Platforms.
They MAY/MAY NOT send text messages/emails via ADIT phone system software to confirm appointments.

I give permission for the following person(s) over age 18 to accompany my child(ren) to their appointment(s) and discuss treatment, billing and insurance with our staff members. **I understand that all deductibles and co-pays will need to be collected at the date of service.**
If I am unable to accompany my child(ren) to their appointments, I also give the following person(s) permission to update all outdated paperwork, as well as sign and agree to recommended treatment.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

I understand that my child can only be treated in this office when accompanied by the Parent(s)/Legal Guardian(s), and the above-listed person(s). This authorization will remain in effect unless I ask to revise and/or update this form. Faxed or written notes sent with another adult will not be accepted.

_____ _____

Signature of Parent/Legal Guardian Date