Southern Smiles
pediatric dentistry

REGISTRATION AND INSURANCE INFORMATION

(Please print and fill out both **FRONT** and **BACK**)

PATIENT/PARENT INFORMATION

Patient name(s):			DOB:	
Legal Guardian 1:	Employer:	Home/Cell #:	DOB:	SS#:
Legal Guardian 2:	Employer:	Home/Cell #:	DOB:	SS#:
Street Address:	City:	State:	ZIP Code:	
Email Address:	What is the best way to contact you? (check all that apply) ❑ Text Msg ❑ Home Phone ❑ Mobile Phone ❑ Email			

INSURANCE INFORMATION (PLEASE NOTE IF DIFFERENT FOR ANY CHILD)

Do your children have dental Insurance? ❑ Yes ❑ No	Insurance Company:			
Subscriber's Name:	Subscriber's SS #.:	Birth Date:	Group #:	Policy #:
Who has legal custody of child?	Person responsible for payment of account:			
PHYSICIAN/PEDIATRICIAN NAME:	PHYSICIAN/PEDIATRICIAN – PHONE NUMBER:	PHYSICIAN/PEDIATRICIAN ADDRESS:		

ALTERNATE CAREGIVER CONSENT

I give my permission for the following individuals to bring my child to the dentist:

Name

Relationship Phone #:

Name

Relationship Phone #:

All individuals that bring your child must be aware that they may not leave the facility while your child is receiving treatment. My signature in the adjacent box indicates I am fully aware that the treatment and fees may change and payment is expected in full at the time of service. The treatment plan has been explained to me the office. If we cannot reach the parent for permission, services may not be rendered if someone else brings your child for treatment.

CONSENT FOR DENTAL TREATMENT

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. The information listed on these forms (including the health history and registration paperwork) is complete and accurate to the best of my knowledge.

I give consent for Dr. Mark Herring, associate dentists, and staff to perform a dental examination, dental prophylaxis, fluoride treatment and take x-rays on my child. For the purposes of advancing medical-dental education, I give permission for the use of clinical photographs and x-rays of the patient for diagnostic, scientific, educational, or research purposes. I authorize my insurance benefits be paid directly to the doctor. I understand that I am financially responsible for any balance. I also authorize Southern Smiles Pediatric Dentistry to release any information required to process my claims.

Patient/Guardian signature *Date*

Doctor signature *Date*

PLEASE FILL OUT ONE FORM FOR EACH CHILD

Patient Name (Last, First, Middle)	Nickname/Answers to:	Date of Birth:	Age: _____ yrs _____mon.	Sex: ❑ Male ❑ _____ ❑ Female

Please list any current medications:	Any Drug/Food Allergies? ❑ No ❑ Yes (explain)	Are your child's immunizations current? ❑ Yes ❑ No If No, do you have a delayed plan with your pediatrician (explain):_____

Has your child ever had a health problem ❑ No ❑ Yes If yes, please explain:	Has your child ever been hospitalized, had general anesthesia or an emergency room visit? ❑ No ❑ Yes (please explain):

PLEASE CHECK OFF IF YOUR CHILD HAS BEEN TREATED FOR ANY OF THE FOLLOWING:

_____ Abuse	_____ Cleft Lip/ Palate	_____ Infectious Disease	_____ Recurrent Headaches	_____ Tonsil/ Adenoid Issues
_____ ADHD/ADD	_____ Congenital Birth Defects	_____ Kidney Disease	_____ Respiratory Issues	_____ Thyroid Disease
_____ AIDS/HIV	_____ Diabetes		_____ Rheumatic Fever	_____ Tuberculosis
_____ Anemia	_____ Endocrine/ Growth Issues	_____ Liver Disease/ GI Disease	_____ Seasonal Allergies	_____ Tumors/ Growths
_____ Asthma	_____ Frequent Infections		_____ Seizures/Epilepsy	_____ Visually Impaired
_____ Autism	_____ Hearing Impaired	_____ Mental Delays	_____ Shunts	Other/explain:
_____ Blood Dyscrasias	_____ Heart Disease	_____ Personality/ Social Disorders	_____ Sickle Cell Disease/ Trait	
_____ Bone Disease	_____ Heart Murmur	_____ Pregnant	_____ Sleep Apnea	
_____ Cancer	_____ Heart Surgery	_____ Premature delivery	_____ Speech Issues	
_____ Cerebral Palsy	_____ Hepatitis	_____ Radiation Treatment	_____ Spina Bifida	

DENTAL HISTORY

What is the reason for your child's visit today?
_____

Has your child ever been to the dentist? ❑ Yes ❑ No
Date of last cleaning & x-rays_____

Name/Location of previous dentist/ office: _____

Has your child had local anesthetic? ❑ Yes ❑ No

Has your child experienced any unfavorable reaction from previous dental care? ❑Yes ❑ No _____

Has your child been sedated for dental treatment? ❑ Yes ❑ No
_____

Have your child's teeth ever been injured? ❑ Yes ❑ No
_____

Does your child suck a finger, thumb or pacifier? ❑ Yes ❑ No
_____

Does/did your child go to bed with a bottle/sippy cup? ❑ Yes ❑ No
_____

Does your child smoke/chew/vape tobacco? ❑ Yes ❑ No
_____

Please circle if your child is having problems with any of the following:

Cavities	Toothache	Sensitivity	Mouth Breathing	Trauma
Color of Teeth	Orthodontics	Jaw Sounds	Grinding	Gum Infections

FLUORIDE HISTORY

Is your home water supply fluoridated? ❑ Yes ❑ No

Do you use well water at your residence? ❑ Yes ❑ No

Does your child use fluoridated toothpaste? ❑ Yes ❑ No

Do you give your child any other forms of fluoride? ❑ Yes ❑ No

_____

Does your child participate in a school fluoride program? ❑ Yes ❑ No

TONGUE-TIE / LIP-TIE

Does/did the child have any issues with **BREASTFEEDING** - Issues can include poor latch, incomplete feeding, clicks/pops during feeding, weight loss, or painful breastfeeding.

❑ Yes ❑ No ❑ Did not breastfeed

Does/did the child have any issues with **EATING/GAGGING** – Issues can include slow eating, picky about foods or textures, gagging/vomiting during/or after meals, gassiness/stomachaches

❑ Yes ❑ No

Does/did your child have any issues with **SPEECH** – Issues can include delayed speech, poor pronunciation, mumbling/talking softly, not meeting speech milestones?

❑ Yes ❑ No ❑ My child is under 2y old

❑ Yes ❑ No Has anyone said your child has a lip or tongue tie?
❑ Yes ❑ No Has your child had a lip/tongue tie correction?

SOUTHERN SMILES PEDIATRIC DENTISTRY – APPOINTMENT POLICY

At Southern Smiles Pediatric Dentistry, we understand our parents and patients have busy schedules! We want to make sure that your children are seen in a timely and efficient fashion. We also want to be able to help children in pain, or who have sudden emergency care needs. Our appointment policy allows us to do both of these so that we can accommodate all of your child's needs.

Below is a description of our standard policies and procedures for any possible missed appointments or appointments cancelled with less than a 24-hour notice. Please read the policy below and let us know if you have any questions. Then, sign at the bottom of the page stating that you have read and understand our missed/cancelled appointment policy.

****

If you cancel a scheduled appointment with less than 24-hour notice or if you completely miss/no-show a scheduled appointment without notice, as a courtesy you will be provided a one-time grace appointment for which you can reschedule the 1st missed/cancelled appointment. If you cancel the 2nd scheduled appointment with less than 24-hour notice or if you completely miss/no-show the appointment without notice, your family will kindly be dismissed from the practice.

****

I have read and understand the appointment policy for Southern Smiles Pediatric Dentistry.

_____ _____

Parent/Guardian Signature Date

SOUTHERN SMILES PEDIATRIC DENTISTRY - PARENT POLICY

Welcome to Southern Smiles! Our highly trained pediatric team is committed to working together to provide a safe and positive experience for your child. We understand that having dental work completed may be new to your child and that your role as a parent is important in helping to overcome any fear or anxiety your child may have. Parents are more than welcome to accompany their children during dental visits at Southern Smiles, but we strongly encourage parents to think carefully about whether their presence will be a positive or negative influence on their child's behavior.

Your child's safety and well-being, both physical and mental, is our number one priority and the doctor will be happy to discuss any concerns you have while keeping your child's best interest in mind. Our team members here at Southern Smiles have extensive training in pediatric behavior management and have put guidelines in place that will allow our team to work efficiently with your child to promote a positive dental experience.

Please read through the following and sign below. A copy of this policy is always available upon request.

No open food or beverages in the operatory. Tooth bugs are in the air- don't drink them! If you choose to take a beverage to the back, please make sure that it has a lid on it and drink at your own risk!

No phone calls! Enjoy your texting, email, or browsing the web, but please silence all ringers, and do not answer phone calls while you are in the clinical treatment area.

Please save all pictures until after the appointment and ask for permission. We love pictures, however, please refrain from taking pictures of those pearly whites until after your child's appointment is completed. Additionally, for HIPAA compliance and patient privacy, please ask prior to taking pictures to ensure that no one else's privacy is being violated.

Three's a crowd - only one parent per patient is allowed back. Mom and Dad can feel free to tag team or swap out as needed. No children are allowed to be unattended in the waiting area.

Please be aware that we have a 10-minute grace period for appointments. If you arrive more than 10 minutes late for a scheduled appointment, we will need to evaluate our schedule and consult with the clinical team to see if we will still be able to accommodate.

Parent must remain in the office. Your child's safety is our number one concern. While your child is here for their visit please remain in the office at all times.

Once procedures start, we ask that parents stay seated for the duration of the appointment for the safety of the patient, parent, and the dental team members. Parents are not allowed to stand in the working area of the dental team, unless specifically approved by the doctor.

Parents are asked to be "silent observers." Please allow your child to concentrate on members of the dental team or the kid approved movie on the television above them.

Parents may be asked to step into the hallway or return to the waiting room if the doctor feels it is in the best interest of the child. Many times children do an awesome job while parents are not watching!

I have read the Southern Smiles Pediatric Dentistry Policy and agree to the rules and regulations. I understand that these guidelines exist to provide the best dental experience for my child(ren). Failure to abide by these rules will result in dismissal of all related patients being treated at Southern Smiles Pediatric Dentistry.

PRINT NAME_____SIGNATURE_____DATE_____

Southern Smiles
pediatric dentistry

INSURANCE DISCLAIMER

(Please read carefully)

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits **it is not a guarantee of payment** by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Any treatment plan that our office proposes to you is an **estimate** of what your insurance coverage will be, it is not a guarantee. If you need exact payment of benefits, then a *pretreatment estimate* is required. If you would like this done, you must specify to a guest relations associate before any work is initiated. (This takes 6-8 weeks). _____ (Initial)

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. If your insurance plan does not pay within 120 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan. If your dental plan pays more than expected, you will receive a refund check.

Also remember dental insurance plans are not designed to cover all of your dental needs. I, _____, have chosen to allow Southern Smiles Pediatric Dentistry to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within 120 days of my date of service then I will become responsible to pay at that time.

Print Name: _____ Date: _____

Responsible Party Signature: _____

Patient Name: _____

Staff Signature: _____

Southern Smiles Pediatric Dentistry
Authorization for Release of Information

Name of Patient _____
Date of Birth _____
I, _____ authorize Southern Smiles Pediatric Dentistry to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other_____
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the following disclosures:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the following disclosures:	☐ Appointment reminder ☐ Other: _____
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other	☐ May be posted in office ☐ May be posted on website ☐ Other_____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by patient

X_____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A copy of our privacy practice is located in our waiting room, if you would like a personal copy of our privacy practice, please ask one of our guest relations associates.

I have received a copy of this office's Notice of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

_____

Please print name

_____

Signature

_____

Date

For Office Use Only

The patient was offered a copy of the Notice of Privacy Practices. An attempt was made to obtain a signature on this Acknowledgement of Receipt for the Notice. It could not be obtained because:

- ☐ An emergency existed and a signature was not possible at the time.
- ☐ The individual refused to sign.
- ☐ A copy was mailed with a request for a signature by return mail.
- ☐ Unable to communicate with the patient for the following reason:
- ☐ Other: _____

Received by: _____Date:_____

Staff Member Name