



**montgomery
pediatric
dentistry &
orthodontics P.C.**

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THE FOLLOWING INFORMATION IS NECESSARY FOR US TO UNDERSTAND AND ADEQUATELY TREAT YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

PATIENT INFORMATION:

Name _____ Nickname _____ Age _____
 Sex _____ Date of Birth _____ Home Phone _____
 Address _____
Street City State Zip
 Child's Social Security Number _____
 For confirmation purposes only: email address _____
 Cell Phone Number: _____
 Person to contact in case of emergency (not living in same household) _____
 With whom does patient live _____
 Other children in your family that we have seen _____
 Child's interests and hobbies _____
 School child attends _____

PARENT / GUARDIAN INFORMATION:

Parent's Marital Status: Married Widowed Divorced Separated Single

Father:	Mother:
Name _____	Name _____
Date of Birth _____ SS# _____	Date of Birth _____ SS# _____
Drivers License # _____ State _____	Drivers License # _____ State _____
Employer _____	Employer _____
Address _____	Address _____
Occupation _____	Occupation _____
Business # _____ Ext. _____	Business # _____ Ext. _____
Dental Ins. _____	Dental Ins. _____
Group # _____	Group # _____
Responsible Party _____	
Billing Address if different from residence _____ <small>(First and Last name please)</small>	
Whom may we thank for referring you to our office? _____	

Please check any information pertinent to your child.

Pediatrician _____

Medical History

	Yes	No	
Does your child have any significant health problems? If so, then explain. _____	_____	_____	___ Emotional Disorder
Does your child have regular medical exams?	_____	_____	___ Sickle Cell Anemia
Is your child up to date with immunizations?	_____	_____	___ Bleeding Disorder
Is your child taking any medications? If so, please list _____	_____	_____	___ Hearing Disorder
Has your child been hospitalized since birth? If so, then explain _____	_____	_____	___ Nervous Disorder
Has your child had any unfavorable reactions to any medicines? If so, then list _____	_____	_____	___ Heart Condition
Has your child ever been diagnosed with any type of heart problem?	_____	_____	___ Mental Condition

Dental History

Is this your child's first dental visit? If not, date of last visit _____	_____	_____	___ Speech Disorder
Has your child had an unfavorable experience at another dental office?	_____	_____	___ Vision Disorder
Do you expect your child to be a cooperative patient?	_____	_____	___ Rheumatic Fever
Is your child presently on a fluoride supplement?	_____	_____	___ Cerebral Palsy
Is your child a finger sucker?	_____	_____	___ Kidney Disorder
Does your child use a pacifier?	_____	_____	___ Liver Disorder
Has your child ever experienced trauma to the teeth, face, or jaws? _____	_____	_____	___ Brain Disorder

_____ Tuberculosis
_____ Retardation
_____ Allergies
_____ Hepatitis
_____ Diabetes
_____ Epilepsy
_____ Asthma
_____ Autism
_____ HIV+
_____ Recurrent Headaches
_____ Transfusions
_____ Leukemia
_____ Cancer
_____ Spina Bifida
_____ Latex Allergy
_____ Pregnant
_____ Other _____

What is your water source?
Private Well _____ Public System _____

Reason for Today's Appointment

Check up and Cleaning _____ Exam Only _____ Evaluate Crowding _____ Toothache _____ 2nd Opinion _____
Other _____

PERMISSION:

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all dental services can be performed by Montgomery Pediatric Dentistry, P.C. Authorization is hereby granted to Montgomery Pediatric Dentistry, PC and shall remain in force and effect until cancelled by either party.

Signed _____ Relationship _____ Date _____

GENERAL INFORMATION AND CONSENT

We are pleased to receive your child as a patient in our office and feel honored by the confidence you have placed with us. We sincerely desire to make his or her visits as pleasant as possible. We feel that we can better establish a patient-doctor relationship if our parents and patients are familiar with the service and procedures of this office.

INITIAL VISIT: Each child receives a thorough examination on their first appointment. It usually includes a prophylaxis (cleaning of the teeth), topical fluoride, and dental x-rays, if they are needed. Oral hygiene instructions will be given to the patient and reviewed with the parent along with dietary recommendations. We employ all procedures available to reduce radiation risk including thyroid and gonadal lead apron, collimated x-ray machine and the fastest film available today. We feel that it is extremely important for a child to have a full mouth x-ray (panorex) starting around the age of 5 or 6 to check for any problems such as extra permanent teeth, congenitally missing teeth, cysts or eruption problems.

NITROUS OXIDE (LAUGHING GAS): Frequently, we will employ the "Happy Air Mask" (nitrous oxide) to help reduce anxiety and fear of dental procedures. It is tremendously effective when treating children and is very safe.

PREMEDICATION: It is often necessary certain dental procedures to premedicate patients with heart problems or joint replacements using antibiotics. Please make us aware if your child has ever had any of these conditions.

HOSPITALIZATION: Some young or handicapped children requiring extensive treatment would benefit by having their work done under general anesthesia in the hospital setting. If we feel this is a necessary way to treat your child, we will thoroughly discuss hospitalization with you.

ORTHODONTICS: At each six month hygiene appointment your child will be checked for proper eruption of teeth and/or any malocclusion that may be developing. We will inform you of any treatment that we feel is necessary for your child. For your convenience we have an orthodontist on staff who would be happy to evaluate, discuss, and treat any of your child's orthodontist needs.

CHILDREN'S TIME: Although we schedule appointment times for the treatment of your child, our office operates on "children's time." This means that occasionally some of our patients who are not particularly interested in getting their dental work done may take extra time to be made more comfortable and less apprehensive. This will invariably play havoc with our schedule and cause some delays. So let me personally apologize for running behind now! We are guilty of letting our patients manipulate the schedule somewhat when we are trying to give them the best possible dental experience. We also see many emergencies since children may have accidents at home, school or play.

PLEASE LET US KNOW IF YOU OBJECT TO THE USE OF FLUORIDE AND/OR X-RAYS
We intend to render dental services to your child as we would our own. If at any time you have questions concerning your child's dental health, please feel free to ask us.

FINANCIAL POLICY

- 1) **Insurance Patients:** We understand the value of dental insurance benefits. We will gladly process your claim for you and will also estimate the portion that is not covered by insurance. This copayment is due at the time services are rendered. Our estimates are based on information that you have furnished us regarding the benefits of your company plan.
- 2) **Non-Insurance Patients:** Payment is due at the services are rendered unless other arrangements have been made with our financial coordinator.
- 3) **Payment Options:** Cash, Money Orders, Personal Checks, Visa, and Mastercard.

I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS FORM AGREEMENT TO PAY

The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees, and court costs if such be necessary, waving now and forever the right to claim exemption under the constitution and laws of the State of Alabama, or any other state.

Parent's Signature _____

Child's Name _____

Reviewed by _____ Date _____