LITTLE HARPETH
CHILDREN'S DENTISTRY

"Whale-come"

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will keep their smile beautiful for their lifetime.

Email _____

☐ Mother

☐ Stepmother
☐ Guardian

First _____ M.I. ___
Last _____
Home Ph _____
Work Ph _____
Cell _____
SS#SIN#_____
Date of Birth _____
Employer _____
Occupation _____
DL# _____

Your Child

Child's First _____ M.I. ___
Last _____
Preferred _____ Sex ____
Date of Birth _____ Age_____
SS#SIN _____
School _____ Grade _____
Child's Home Address
_____
City _____
State /Prov _____
Zip/P.C. _____
Phone _____

☐ Father

☐ Stepfather
☐ Guardian

First _____ M.I. ___
Last _____
Home Ph _____
Work Ph _____
Cell _____
SS#SIN#_____
Date of Birth _____
Employer _____
Occupation _____
DL# _____

Primary Dental Insurance

Insured's Name _____ Relationship _____
Date of Birth _____ SS#SIN _____ Employer _____
Ins. Company _____ Group# _____ ID#_____

Additional Insurance: Insured's Name _____ Relationship _____
Date of Birth _____ SS#SIN _____ Employer _____
Ins. Company _____ Group# _____ ID#_____

Responsible Party

First _____ M.I. _____
Last _____
Relationship _____
Address _____
_____
Home Ph _____Work Ph _____
Cell _____

Parent's Marital Status

☐ Single ☐ Divorced
☐ Married ☐ Widowed ☐ Separated

How did you hear about us?

_____

Health History

Your child's overall health as well as any medications which your child takes could have an important relationship with the dental care your child receives. Please answer each of the following questions completely.

Child's Habits

How often does your child brush? _____

How often does your child floss? _____

Date of your last dental visit _____

Previous Dentist _____

Child's Physician _____

Physician's Number _____

Child's Date of Birth _____

Is your child's water fluoridated?.....☐ Yes ☐ No

Does your child take fluoridated supplements? ☐ Yes ☐ No

Does Your Child:

Speech issues/ tongue tie.....☐ Yes ☐ No

Suck thumb/finger .....☐ Yes ☐ No

Suck/bite lips .....☐ Yes ☐ No

Chew/bite nails .....☐ Yes ☐ No

Chew hard objects (pencils, etc.) .....☐ Yes ☐ No

Grind teeth .....☐ Yes ☐ No

Clench jaws .....☐ Yes ☐ No

Health History

Has your child had difficulty w previous visits? ___

Has your child ever had sleep apnea or snore while sleeping? _____

All immunizations up to date? REQUIRED _____

Any birth complications? _____

Has your child ever had any of the following:

Asthma ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Allergies ☐ Yes ☐ No
Autism ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No

SBE prophylaxis (antibiotic premedication required) ☐ Yes ☐ No
Handicaps/Disabilities ☐ Yes ☐ No
Convulsions/Epilepsy ☐ Yes ☐ No
Abnormal Bleeding ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
ADHD/ADD ☐ Yes ☐ No

Previous Surgeries ☐ Yes ☐ No (if yes, what?) _____

Please explain any medical problems that your child has

_____

Please list any medications your child may be taking

_____

Please list any medications your child may be allergic to

_____

AUTHORIZATION & RELEASE:

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is m responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature: _____ Date: _____

(Patient or Parent/Guardian if Minor)

LITTLE HARPETH
CHILDREN'S DENTISTRY

Doctor Treatment Authorization

Thank you for choosing Little Harpeth Children's Dentistry as your child's dental care provider. Our main focus at Little Harpeth Children's Dentistry is to ensure that your child has a positive dental experience. Our doctors are uniquely trained to care for the oral health and dental development of infants, children, adolescents and special needs patients.

By signing below, I hereby authorize Dr. Priya Purohit and her associates to perform any and all necessary preventative and/or restorative procedures that they deem necessary, with the consent of the parent or legal guardian. These procedures may include, but are not limited to photographs, x-rays, fluoride treatments, fillings, extractions, crowns, the administering of nitrous oxide, and/or sedation medications and other dental procedures.

Should you have any reservations, please see the receptionist. Otherwise please sign the below authorization.

_____

Parent or Legal Guardian

_____

Print Name of Patient

_____

Date

Little Harpeth Children's Dentistry
7640 Highway 70S, Suite 101
Nashville, TN 37221
LittleHarpethChildrensDenistry.com

LITTLE HARPETH
CHILDREN'S DENTISTRY

Authorization for Treatment

In my absence, I hereby authorize (Please list all of the people and their relationship who will be allowed to bring your child to the office for treatment)

_____

_____ to accompany (print child's name) _____

for necessary preventative and/or restorative appointments to Little Harpeth Children's Dentistry as deemed by Dr. Priya Purohit and her association dentists as well as LHCD staff. These procedures could include photographs, x-rays, fluoride treatments, nitrous oxide, possibly even sedation medications. The aforementioned person has my full permission to make decisions concerning treatment of my child, both the day of the appointment and any future appointments. As witnessed by my signature, I will indemnify and hold harmless Dr. Priya Purohit and her associates and the LHCD staff, for all claims arising out of my consent for my child to be treated.

_____

Signature of Legal Guardian

_____

Print Name of Parent or Legal Guardian

_____

Date

Little Harpeth Children's Dentistry

Your Privacy is Important to Us!

Acknowledgement of Receipt of Notice of Privacy Policies
(Minor)

I have received a copy of the Notice of Privacy Practices of Little Harpeth Children's Dentistry. I hereby authorize, as indicated by my signature below, Little Harpeth Children's Dentistry to use and to disclose my protected health information for any necessary clinical, financial and insurance purpose, as authorized in the Patient Consent form.

_____ _____

Parent or Legal Guardian Address

_____ _____

Signature Date

Please check your preferred means of communication:

- ☐ You may contact me at my home telephone number. _____
- ☐ You may contact me at my mobile telephone number. _____
- ☐ You may contact me on my work telephone number. _____
- ☐ You may send me an email at: _____
- ☐ Other: _____

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial and legal guardians:

1. _____ Date Added/Removed: _____
2. _____ Date Added/Removed: _____
3. _____ Date Added/Removed: _____
4. _____ Date Added/Removed: _____
5. _____ Date Added/Removed: _____

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining the acknowledgement
- ☐ Other (Please Specify): _____

Office Policy & Patient Consent for Minors

Thank you for choosing Little Harpeth Children's Dentistry as your child's dental care provider. Our dental health team is committed to excellence in dental care in a friendly comfortable environment. It is very important to us as your dental care provider to utilize every means necessary to provide the best dental care possible. We ask that when you have an appointment, please call and confirm the appointment to ensure that we still have availability. Unconfirmed appointments are not guaranteed and may be given away in the case of an emergency. Confirmed appointments can be counted against you if the appointment is not kept of if we are not notified within 24 hours of the appointment.

The courtesy of a two-day notice is appreciated should you need to cancel or reschedule your child's appointment. A $50 cancellation fee will be assessed for missed appointments within a 24-hour notice. After three (3) missed appointments, you may be asked to find another provider.

Insurance

At LHCD, we are not contracted with all insurance companies. It is your responsibility to make certain your insurance plan will pay for your visit. Of course, we will be happy to assist you; however, please understand that your insurance policy is a contract between you and your insurance company. We are a third party and have limited availability to act on your behalf; therefore, we do not guarantee insurance benefits. Estimated co-pays will be due at the time of service. Upon signature of this policy and consent form, you authorize the office to release to staff, hospitals, healthcare service plans, insurance companies, self-insurers or the representatives, any and all information, records, and radiographs regarding the patient's medical history, services rendered or recommended treatment. You also authorize the practice to submit claims electronically and/or manually for payment for services rendered or pre-authorizations deemed necessary by your insurance company. When such claims are submitted to the insurance company or third party on your behalf or your patient's behalf, your name will be listed as "Signature On File" and will assign to the practice the insurance benefits, providing assignment is accepted. You are responsible for payment regardless of the coverage provided.

Any account not paid in full within 60 days will be subject to collection fees. The fees incurred will be the responsibility of the parents and/or guardians. These fees may include, but are not limited to, returned check fees and court costs.

TennCare Patients: Most procedures are covered by TennCare. Payment for procedures not covered (or claims denied due to ineligibility by TennCare are the responsibility of the parent and/or legal guardians. It is your responsibility to make certain your TennCare coverage is in full force prior to your appointment.

Clinical Consent

As the parent/legal guardian of the minor patient(s), I authorize the associated of Little Harpeth Children's Dentistry to perform all recommended treatment on the patient(s).

I authorize the associates of Little Harpeth Children's Dentistry to take radiographs, study models, photos and other diagnostic aids or materials collectively ("diagnosed material") as needed to make a thorough diagnosis. I authorize that such diagnostic material may be released to third-party payers and/or other healthcare professionals.

I have read the Patient Consent and agree to the terms and conditions herein.

Patient Name(s): _____ D.O.B.(s): _____

Signature of Parent ' Legal Guardian: _____ Date: _____

Relationship to Patient: _____ Address: _____