



Dr. Edward C. Perdue, D.D.S., L.L.C.

Diplomate of American Board of Pediatric Dentistry

Dentistry for Children, Teens and Those with Special Needs

(615) 662-2191

TELL US ABOUT YOUR CHILD:

Name: _____

Name called: _____

• Male • Female Age: _____

DOB: _____ Child's SS #: _____

Child's home #: _____

Other siblings/ages: _____

Child's School: _____

MOTHER'S INFORMATION

Name: _____

DOB: _____

Address: _____

Cell #: _____ Home #: _____

Employer: _____

eMail address: _____

DL #: _____ SS #: _____

FATHER'S INFORMATION

Name: _____

DOB: _____

Address: _____

Cell #: _____ Home #: _____

Employer: _____

eMail address: _____

DL #: _____ SS #: _____

Nearest relative not living with you:

Name: _____

Address: _____

Cell #: _____ Home #: _____

Who has legal custody of this child? _____

How did you hear about us? _____

Why did you come to see us today? _____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- heart murmur
- congenital heart defect
- rheumatic fever
- anemia
- hepatitis
- convulsions
- mental retardation
- Down's Syndrome
- cleft lip/palate
- eye problems
- tuberculosis
- diabetes
- asthma
- HIV /aids
- blood transfusions (date/s: _____)
- bleeding
- epilepsy
- herpes/cold sores
- cerebral palsy
- liver/kidney
- speech/hearing
- autism
- fainting
- emotional, mental, or nervous disorder

Other: _____

Does your child have any of the following?

- thumb/lip sucking
- discolored teeth
- pacifier
- teeth sensitive
- toothache
- jaw pain
- cavities
- crooked teeth
- bumped/broken teeth

Was your child bottle or breast fed? • Yes • No

Age stopped bottle or breast feeding: _____

Is your water fluoridated? • Yes • No

Does your child take fluoride supplements? • Yes • No

Is this your child's first dental visit? • Yes • No

Has the child ever had a serious or difficult problem with dental treatment? • Yes • No

If yes, please explain: _____

CHILD'S PHYSICIAN

Name: _____

Phone #: _____

Date of last physician visit: _____

Is the child presently under the care of a physician? • Yes • No

If yes, please explain: _____

Please list all drugs to which the child is allergic:

Please list all drugs that the child is currently taking:

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Billing address: _____

City, State, ZIP: _____

Cell #: _____ Home #: _____

DOB: _____ SS #: _____

How do you prefer to pay: • Cash • Check

• CITI HealthCard #: _____

• MasterCard/VISA #: _____

GUARDIAN & FINANCIAL INFORMATION

Dr. Edward C. Perdue and his staff are committed to providing your child with the best possible care. Dr. Perdue is a Board Certified Pediatric Dentist, and he adheres to the guidelines recommended by the American Association of Pediatric Dentistry and the American Dental Association for his treatment recommendations for your child.

Since your child is a minor, it is necessary that signed permission be obtained from the parent/guardian before any and/or all dental services can be performed by Dr. Perdue and/or associates. Authorization is granted by signing below. If you have dental or medical insurance, we are eager to help you receive your maximum allowable benefits. The coverage provided by insurance companies varies from company to company. It is impossible for our office to know how much each company pays for each procedure and what they do not cover. Therefore, it is important for you to familiarize yourself with your Insurance coverage.

The fact that your insurance chooses not to cover a certain dental procedure does not mean that the procedure is not important for your child. Generally, a way in which your employer seeks to minimize the cost of insurance is by eliminating coverage of certain dental procedures, even though they are necessary in providing the best dental care for your child.

PRIMARY DENTAL INSURANCE

Ins. Co. Name: _____

Address: _____

Phone #: _____

Group #: _____ Policy #: _____

Insured's name: _____

Relationship to patient: _____

Insured's DOB: _____ SS #: _____

Insured's Employer: _____

Orthodontic coverage? • Yes • No

SECONDARY DENTAL INSURANCE

Ins. Co. Name: _____

Address: _____

Phone #: _____

Group #: _____ Policy #: _____

Insured's name: _____

Relationship to patient: _____

Insured's DOB: _____ SS #: _____

Insured's Employer: _____

Orthodontic coverage? • Yes • No

TennCare? • Yes • No #: _____

As dental care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we are happy to extend to our patients, all charges are your responsibility from the date the services are rendered. Payment for services is due at the time services are rendered. If, however, you are covered by dental insurance, then you will be expected to pay your estimated portion at said time. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We accept cash, checks, MasterCard, Visa, Discover, and CitiHealthCard (a medical/dental account). Should it be necessary to take action to collect any amount owing under this agreement, you agree to assume the cost incurred to collect including, but not limited to, collection agency fees, attorney fees, court costs, and interest accruing thereon at the rate of 1 1/2% per month.

I have read and understand the above information. Furthermore, I understand that certain dental procedures may not be covered by my insurance. I want the procedures rendered that represent the standard of care as presented by the American Academy of Pediatric Dentistry and the American Dental Association. I agree to pay for any expenses not covered by my insurance. I understand that should there be a procedure that I do not wish to be performed on my child, that I must notify the office prior to my child's visit. By signing below, I am also giving consent for Dr. Perdue and associates to perform dental services for my child.

Father: _____ Date: _____ Mother: _____ Date: _____

THREE IMPORTANT POLICIES

A policy is a written statement that determines actions or activities of an organization. We have three important policies in our practice we feel important to share with you, our patient. We have put them in writing because we live by them and require that all our patients live by them as well. We realize that the institution of these three policies may be different from what you may be accustomed to in the past; however, we believe they are very necessary. We ask you to read them thoroughly and then sign in the presence of a staff member to indicate that you understand these policies and agree to comply with them.

I :: Commitment to Treatment Policy

We believe that all treatment begun should be completed. Incomplete treatment leads to problems, complications and misunderstandings. Incomplete treatment leads to loss of teeth and further disease. Some treatment plans, because of their design, take several appointments to complete. Therefore, this policy states that all agreed-upon treatment plans, once they are started, will be completed.

II :: Commitment to Financial Agreement

We believe we have a responsibility to use our best professional care, skills and judgment in planning for your dental treatment. Our office operates on a fee-for-service basis. For patients without dental insurance, we accept MasterCard, Visa, American Express and Discover, as well as cash and checks. Any insurance program is solely between you, as a patient, and the carrier of your insurance. We are happy to assist you in filing your insurance; however, the responsibility for payment for our services is yours. By signing below, you indicate that you agree that all fees should be properly explained to you and you agree to fulfill your financial commitment to our office, promptly and completely. No business or practice can fulfill its mission to its patients when a bond of trust is violated by failure to pay for services. Not living up to this trust violates this important business principal. In the event that this account must be placed with a collection agency, you agree to pay collection and attorney fees incurred to collect this account.

III :: Commitment to Appointment Policy

We RESERVE quality time for each patient in our practice. An appointment in our schedule with your child's name on it is a bond of trust, assuring we will be here to serve you and you will be present for that reserved time. Our office policy in this regard is extremely firm. Any missed appointment or appointment that is canceled with less than 24 hours' notice will be charged a non-compliance fee of \$50. After the third missed appointment, your child will be dismissed from the practice. Due to federal regulations, we are unable to charge TennCare patients this fee; therefore, they will be dismissed from the practice after the first missed appointment. We realize the value of your time, and ask that you give equal respect to our time.

There are certain procedures that will be scheduled at specific times in order to provide your child with the best possible care. In the event that you arrive late for your reserved appointment, please understand that we may not be able to see your child on that day.

We appreciate your cooperation with these scheduling policies. Helping Dr. Perdue and our staff successfully attend to your child's needs in a timely manner will bring your child closer to becoming part of the cavity-free generation!

Parent/Guardian: _____ Date: _____ Staff Member: _____ Date: _____

PATIENT'S RIGHTS

I understand that I have the privilege of accessing healthcare or to be referred to an appropriate doctor.

I understand that I have a right to my doctor's best efforts to help me achieve my health goals.

I understand that I have a right to access urgent care in keeping with the seriousness of the problem/s I report to my doctor and/or the office staff.

I understand that I have a right to be treated with courtesy and respect by all doctors and staff.

I understand that I have a right to be given important information that I may need in order to make the best possible decisions about my ongoing healthcare.

I understand that I have a right to ask questions about my health and treatment options - and to have those questions answered in a manner I can understand.

I understand that I have a right to have the risks and benefits of the proposed diagnostic or treatment options explained to me in a manner that I can understand, and that I have the right to give my consent before treatment commences.

I understand that I have a right to tell my doctor when I would like a second opinion. This means that I can ask for a referral to another specialist, or that I can contact my insurance plan, local hospital or medical society for a referral.

I understand that I the doctors and staff will do everything possible, within the ethical constraints of dentistry, and within the letter of the law, to maintain both the confidentiality and the security of my records.

If I choose to transfer my care elsewhere, I understand that I have a right to a copy of my dental records, and that they should be made available to me within 14 business days of my request.

PATIENT'S COMMITMENT

I understand that it is important that I work with my doctor to establish and reach my dental goals.

I understand that it is important that I keep my doctor informed about changes in my symptoms, general health, medications, side effects and diagnoses received from other practitioners, or any concerns about my current health status.

I understand that it is important that I treat my doctor and doctor's staff with courtesy and respect.

I understand that it is important that I participate with my doctor in making decisions about my ongoing healthcare. I will, to the best of my ability, act as a partner in this important undertaking.

Patient/Parent/Guardian: _____ Date: _____ Doctor: _____ Date: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTE: You MAY refuse to sign this acknowledgment of receipt of notice of our Privacy Practices.

I, _____, have received a copy of this office's Notice of Privacy Practices.
[printed name]

Signature: _____ Date: _____

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communication barrier prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining the acknowledgment
- Other (please specify): _____

When you have completed this form...

- Save a copy of it, in PDF format, on your computer (for your records)
- Print a copy of it, and bring it to your next appointment at Dr. Perdue's office
- Please give it to a member of Dr. Perdue's staff when you arrive.