



Beech Lake Pediatric Dentistry

P.O. Box 556, 10855 Hwy 412 West, Lexington, TN 38351

Welcome

We are pleased to welcome you and your child to our practice. Our goal is to educate, motivate, and promote good oral health that will last a lifetime. Please take a few minutes to fill out this form completely. Please mark "SAME" or "N/A" where appropriate.

1. Tell Us About Your Child

Child's Name: _____ Nickname: _____ Male / Female
 Home Address: _____ City _____ State _____ Zip _____
 Phone: (____) _____ SSN: _____ Child's Birth Date: ____/____/____ Age: _____
 School: _____ Grade: _____ Special interests/ Pets: _____
 Emergency Contact: _____ Phone #: (____) _____

2. Person Accompanying The Child

Name: _____ Relation to child: _____
 Address: _____ City _____ State _____ Zip _____
 Phone: (____) _____ Work #: (____) _____ Ext: _____ Cell #: (____) _____
 Are you the legal guardian of this child? **Yes / No** Are you the person responsible for the account? **Yes / No**
 If no, please name the legal guardian / responsible party: _____
 How did you hear about us? _____ *Whom may we thank for referring you: _____

3. Parent's Information

Marital Status: Married Single Divorced Separated Widowed

Mother

Step Mother Guardian

Name: _____ Birthdate: ____/____/____ SSN: _____
 Phone: (____) _____ Wk# :(____) _____ Email: _____
 Employer: _____ Occupation: _____ DL#: _____

Father

Step Father Guardian

Name: _____ Birthdate: ____/____/____ SSN: _____
 Phone: (____) _____ Wk# :(____) _____ Email: _____
 Employer: _____ Occupation: _____ DL#: _____

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4. Child's Dental History

Why did you bring your child to the dentist today? _____

Is your child having dental problems at this time? If so, explain _____

Has your child had any unfavorable dental experiences? If so, explain _____

Date of last dental visit: _____ Previous dentist's name: _____

Is your child's drinking water fluoridated? **Yes / No** Is your child taking fluoride supplements? **Yes / No**

How often do your child's teeth get brushed? _____ How often do they get flossed? _____

Does your child have any of the following dental habits?

Y N Thumb/ finger sucking	Y N Nursing/ bottle habits	Y N Bites/ chews objects	Y N Mouth breather
Y N Pacifier	Y N Grinds/ clenches teeth	Y N Tongue thrusting	Y N Pain in jaw (TMJ)

5. Child's Medical History

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

Y N Asthma	Y N Behavioral problems	Y N Diabetes	Y N HIV / AIDS
Y N Heart Murmurs	Y N Cancer	Y N Hepatitis	Y N Nervous disorders
Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Handicaps/ Disability	Y N Rheumatic Fever
Y N ADD/ ADHD	Y N Convulsions / Epilepsy	Y N Hearing Impairments	Y N Speech delays
Y N Any hospital stays	Y N Develop./ Learning delays	Y N Hemophilia	Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

Child's physician: _____ Phone #: (____) _____ Last Visit: _____

Child's pharmacy: _____ Phone #: (____) _____

Please list any drugs your child is currently taking: _____

Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals

Other: _____

6. Consent for Treatment

I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Burke, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understand that Dr. Burke and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.

Signature of parent or guardian

Date

7. Payment Information Please read the following:

Patient's portion of payment is due at the time of service. We will gladly submit your insurance claim for you; however, we do require any deductibles, co-payments, and "estimated" patient portions be paid at the time of service. **PLEASE UNDERSTAND** that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not do with each claim. **WE ALSO CANNOT BE RESPONSIBLE FOR ANY ERRORS IN FILING YOUR INSURANCE.** Once again, we file claims as a courtesy to you.

We accept cash, checks, Debit cards, Visa, and MasterCard.

We also offer financing through a separate company. This, however, requires credit approval from an outside agency and minimal monthly payments. If you are interested in this program, ask one of our front office staff for more information.

Unpaid balances over 60 days will accrue a **monthly fee** equal to 18% APR. Balances over 90 days will be turned over to a collection **agency**; In this event, **you will be responsible for all collection and legal fees.**

If a check is returned NSF, there will be a **\$25.00 check return fee**; from that point on, checks will not be accepted. A **missed appointment charge** of \$50.00 might be applied to your account if less than 24 hour notice is given.

8. Insurance Information

Policy Holder's Name: _____ **Birthdate:** ____/____/____ **SS#:** _____
Insurance Name: _____ **Ins. Phone:** (____) _____
Ins. Address: _____
Policy ID#: _____ **Group #:** _____ **Policy Holder's Employer:** _____

Secondary Insurance (if applicable)

Policy Holder's Name: _____ **Birthdate:** ____/____/____ **SS#:** _____
Insurance Name: _____ **Ins. Phone:** (____) _____
Ins. Address: _____
Policy ID#: _____ **Group #:** _____ **Policy Holder's Employer:** _____

9. Authorization and Release

I authorize Beech Lake Pediatric Dentistry to submit insurance claims on my behalf. I agree to be responsible for payment of all services rendered on behalf of my dependent. I understand that my dental insurance plan is designed to only **share** in my dental costs, usually covering **50 to 80%** of the total dental bill. I understand the amount of dental benefits I receive is determined by my employer or my insurance company, **not by us.** I understand some dental services may **not** be covered by my insurance plan. I understand it is my responsibility to review my insurance policy and to understand my specific dental benefits. In the event my insurance company has not paid their portion within 60 days, the **balance of the bill will become my responsibility.** I have read and agree to the payment information and release listed above.

Signature of parent or guardian _____
Date

