Appointment Policy

Pediatric Dentistry of Newnan reserves a specific time for your child according to their treatment needs and cooperation level. We make every effort to see your child at their appointed time. Inadvertent delays, such as emergencies and unforeseen patient treatment problems may arise causing schedule changes. If your child’s appointment time is delayed, please accept our apology. Your patience is very much appreciated under these circumstances.

Please arrive 5 to 10 minutes prior to your child’s scheduled appointment. This will allow time to complete any necessary paperwork. If you arrive 15 minutes beyond your appointment time, you may be asked to reschedule for the next available appointment time.

Younger children and children requiring complex dental treatment usually perform better when they are well rested and alert; therefore, morning appointments are highly recommended. We will be happy to provide your child with a signed school excuse to satisfy school attendance requirements.

As a courtesy, our office will attempt to contact you to confirm your child’s appointment; however, we ask that you assume responsibility for your child’s appointed time. If you need to reschedule an appointment, we ask that you provide our office with a 24-hour notice so that we may extend the appointment time to another patient. There may be a $25 fee charged to your account for all appointments that are cancelled and/or broken within less than 24 hrs. Multiple broken appointments (3 or more) without prior cancellation notice may be subject to dismissal from the practice.

If at any time you have questions concerning our appointment policy, please ask our office staff for assistance. We appreciate you trusting us with your child’s dental health.

__________________________________________________________
Parent /Legal Guardian Name printed

__________________________________________________________
Parent/Legal Guardian Signature

__________________________________________________________
Date

__________________________________________________________
Relationship to Patient
Kim J. Mathews, DMD
2401 Newnan Crossing Blvd, Suite 210
Newnan, GA 30265
Phone: 770-251-5777/Fax

Consent For Dental Treatment

I am the parent, guardian or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Kim J. Mathews and her staff to perform any necessary dental services including but not limited to comprehensive examinations, cleanings, x-rays and photographs as necessary for diagnostic purposes, any necessary treatment, and the administration of anesthetics that are deemed advisable by Dr. Mathews, even in the event I am not present when treatment is rendered. I understand that dental treatment for children includes efforts to guide behavior by helping them understand the treatment in terms appropriate for their age. Dr. Mathews will provide an environment that will help children learn to cooperate during treatment including explanations, demonstrations of procedures and instruments, praise and using positive reinforcement. I will be responsible for any charges incurred for my child during dental treatment.

______________________________  ______________________________
Parent/Legal Guardian Name (printed)  Parent/Legal Guardian Signature

______________________________  ______________________________
Date  Relationship to Patient
Welcome to our practice! Please carefully complete this form so that we may better serve you. If you have any questions, we will be happy to assist you. We look forward to helping you maintain your child’s dental health.

**PATIENT INFORMATION**

1. **Tell us about your child**
   - Full Name:_____________________________ Preferred Name:_____________________________ Male:___ Female:___
   - Age:_____ Date of Birth:___________________ Interest/Hobbies/Pets:_________________________
   - Address:________________________________ City:_______________ State:________ Zip:_______
   - Home Phone:_________________________ School:________________________ Grade:________
   - Name(s) and Age(s) of Sibling(s):_____________________________________________________
   - How did you hear about our office?_____________________________________________________

2. **Parent/Guardian Information**
   - ( ) Mother ( ) Father ( ) Step Mother ( ) Step Father ( ) Guardian ( ) Other:_______________
     - Name:_________________________ Preferred Name:_______________ Date of Birth:________
     - Address:________________________ City:_______________ State:________ Zip:_______
     - Home Phone:________________________ Cellular Phone:_________________________
     - Employer:________________________ Occupation:_______________________________
     - Work Phone:________________________ Email:___________________________________
     - Is this person legally responsible for the health care decisions for the above patient? ( ) Yes ( ) No

3. **Parent/Guardian Information**
   - ( ) Mother ( ) Father ( ) Step Mother ( ) Step Father ( ) Guardian ( ) Other:_______________
     - Name:_________________________ Preferred Name:_______________ Date of Birth:________
     - Address:________________________ City:_______________ State:________ Zip:_______
     - Home Phone:________________________ Cellular Phone:_________________________
     - Employer:________________________ Occupation:_______________________________
     - Work Phone:________________________ Email:___________________________________
     - Is this person legally responsible for the health care decisions for the above patient? ( ) Yes ( ) No

List anyone you do not want patient information released to:

List anyone who may accompany your child to an appointment and has permission to make decisions concerning their dental treatment:
4. Electronic Communications

I understand the confidentiality of electronic communications (e-mail, text, etc.) cannot be guaranteed and Pediatric Dentistry of Newnan is not responsible for the confidentiality or security of any message sent to or by me. If any of my contact information changes or at any time I wish to terminate this consent, I agree to notify Pediatric Dentistry of Newnan in writing or in person.

_____ I authorize Pediatric Dentistry of Newnan to contact me via electronic media.

_____ I do not authorize Pediatric Dentistry of Newnan to contact me via electronic media.

5. Dental Insurance Information (If Applicable)

Primary Insurance
Person Who Carries Insurance: ____________________________ Date of Birth: ____________________________
SS#: __________________________ ____________________________ Relationship to Patient: ____________________________
Employer: __________________________ Insurance Company Name: __________________________
Insurance Company Address: __________________________
City: __________________________ State: ___________ Zip: ___________ Phone: __________________________
Group#: __________________________ Policy#: __________________________ Member ID#: __________________________

Secondary Insurance
Person Who Carries Insurance: ____________________________ Date of Birth: ____________________________
SS#: __________________________ ____________________________ Relationship to Patient: ____________________________
Employer: __________________________ Insurance Company Name: __________________________
Insurance Company Address: __________________________
City: __________________________ State: ___________ Zip: ___________ Phone: __________________________
Group#: __________________________ Policy#: __________________________ Member ID#: __________________________

I certify that my dependent(s) is covered by insurance with company __________________________ and I assign directly to Pediatric Dentistry of Newnan all insurance benefits, if any, otherwise payable to me for services rendered. I authorize the use of my signature on all insurance submissions. Pediatric Dentistry of Newnan may use and disclose my child’s health care information to the above named insurance company and their agents for the purpose of obtaining payment of services and determining benefits or the benefits for related services. This assignment will remain in effect until I cancel it in writing.

I have also read copy of Pediatric Dentistry of Newnan’s Notice of Privacy Practices and I am aware that I am entitled to a copy upon request.

__________________________________________
Parent/Legal Guardian Name printed

__________________________________________
Parent/Legal Guardian Signature

__________________________________________
Date

__________________________________________
Relationship to Patient
Patient Name: __________________________ Date of Birth: ____________________________

DENTAL HISTORY

1. What is the reason for today’s visit? ________________________________________________

2. Is this your child’s first visit? ___ Yes ___ No If No, previous Dentist? __________________________

Were x-rays taken? ___ Yes ___ No If Yes, date of most recent x-rays? __________________________

3. Does your child brush daily? ___ Yes ___ No Does your child floss daily? ___ Yes ___ No

4. Has your child had fluoride in any of the following forms?
Fluoride tablets? ___ Yes ___ No Professional topical application? ___ Yes ___ No
Are you on city water? ___ Yes ___ No Are you on well water? ___ Yes ___ No

5. Does your child snack frequently? ___ Yes ___ No If Yes, describe snacks: __________________________
Does your child drink soda or juice? ___ Yes ___ No If Yes, how often? __________________________

6. Have your child’s teeth, mouth, and/or head ever been injured? ___ Yes ___ No
Describe injury: _______________________________________________________________________
When and what age? _____________________________________________________________________
Which teeth were injured? ____________________________
Was treatment provided? ___ Yes ___ No If Yes, describe: _______________________________________________________________________

7. Does your child have any of the following habits?
Bottle when sleeping at nighttime or naptime? ___ Yes ___ No If Yes, what beverage? ________________
Thumb or finger sucking? ___ Yes ___ No When was habit discontinued? __________________________
Pacifier? ___ Yes ___ No When was pacifier discontinued? __________________________
Mouth breathing? ___ Yes ___ No Snoring? ___ Yes ___ No
Grinding of teeth? ___ Yes ___ No Nail biting? ___ Yes ___ No

8. When was nursing/bottle discontinued? _________________________________________________

9. Has your child seen an orthodontist? ___ Yes ___ No If Yes, Orthodontist name: ________________
Is your child currently in braces? ___ Yes ___ No If Yes, date started: __________________________
Currently, which phase? ___ Phase I ___ Phase II

10. Is there anything else you would like to tell us regarding your child’s dental health?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
MEDICAL HISTORY

Name of Pediatrician: ___________________________ Office phone: ________________________
Address: ___________________________________ City: __________ State: ______ Zip: __________

1. Were there any difficulties during the pregnancy/delivery of your child? ___Yes ___ No
   If Yes, please describe: ________________________________________________________________

2. Has your child been hospitalized since birth? ___Yes ___ No
   If Yes, please describe: ________________________________________________________________

3. Does your child have any history of the following medical concerns?

<table>
<thead>
<tr>
<th>General conditions</th>
<th>Developmental</th>
<th>Infectious</th>
</tr>
</thead>
<tbody>
<tr>
<td>___ Arthritis</td>
<td>___ Brain Injury</td>
<td>___ Hepatitis</td>
</tr>
<tr>
<td>___ Asthma</td>
<td>___ Cerebral Palsy</td>
<td>___ HIV Infection</td>
</tr>
<tr>
<td>Controlled?</td>
<td>___ Cleft Lip/Palate</td>
<td>___ AIDS</td>
</tr>
<tr>
<td>Last Attack?</td>
<td>___ Developmental Delay</td>
<td>___ Tuberculosis</td>
</tr>
<tr>
<td>Diabetes</td>
<td>___ Feeding/Eating problems</td>
<td>Other</td>
</tr>
<tr>
<td>___ Gastrointestinal Disorder</td>
<td>___ Growth Problems</td>
<td>___ Adenoids</td>
</tr>
<tr>
<td>___ Heart Disease</td>
<td>___ Hearing Loss</td>
<td>___ Cancer</td>
</tr>
<tr>
<td>___ Heart Murmur</td>
<td>___ Neuromuscular Defect</td>
<td>___ Leukemia</td>
</tr>
<tr>
<td>___ Kidney Disease</td>
<td>___ Orthopedic Problems</td>
<td>___ Fainting</td>
</tr>
<tr>
<td>___ Rheumatic Fever</td>
<td>___ Seizures: Type</td>
<td>___ Headaches</td>
</tr>
<tr>
<td></td>
<td>___ Speech Delay</td>
<td>___ Skin Disorder</td>
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<tr>
<td></td>
<td></td>
<td>___ Sleep Apnea</td>
</tr>
<tr>
<td>Behavior/Learning</td>
<td>___ Spina Bifida</td>
<td>___ Anemia</td>
</tr>
<tr>
<td>___ ADD/ADHD</td>
<td>Hematological (Blood-related)</td>
<td>___ Latex Allergy</td>
</tr>
<tr>
<td>___ Anxiousness/Nervousness</td>
<td>___ Anemia</td>
<td>___ Syndrome</td>
</tr>
<tr>
<td>___ Autism</td>
<td>___ Hemophilia</td>
<td>___ Tonsils</td>
</tr>
<tr>
<td>___ Asperger Syndrome</td>
<td>___ Sickle Cell Trait</td>
<td>___ Tubes in ears</td>
</tr>
<tr>
<td>___ Behavioral Issues</td>
<td>___ Sickle Cell Disease</td>
<td>Other</td>
</tr>
<tr>
<td>___ Learning Disabilities</td>
<td>___ Blood Transfusion</td>
<td>___ Pregnancy</td>
</tr>
<tr>
<td>___ Psychiatric Disorder</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If any checked, please describe further: __________________________________________________________

4. Are your child’s immunizations up to date? ___Yes ___ No

5. Has your child had any allergic reactions to the following?
   Medications? ___Yes ___ No If Yes, please describe?
   Latex? ___Yes ___ No If Yes, please describe?
   Foods? ___Yes ___ No If Yes, please describe?
   Other? ___Yes ___ No If Yes, please describe?
Patient Name:__________________________________ Date of Birth:________________________________

6. Is your child currently taking any medications?

<table>
<thead>
<tr>
<th>Drug</th>
<th>How much? How often?</th>
<th>Reason</th>
</tr>
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<tbody>
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</tbody>
</table>

7. Have you ever been told your child requires antibiotic prophylaxis for dental treatment due to a medical condition (e.g., heart condition)? ___Yes ___ No
If Yes, what medical condition?_______________________________________________________
Physician following medical condition (e.g., Cardiologist)?___________________________________
Address:________________________________________ City:________________________ State:______ Zip:__________
Office Phone:________________________________________

I affirm that all of the above personal and health information I have given is correct to the best of my knowledge. The above information will be held in the strictest confidence. I understand that it is my responsibility to inform Pediatric Dentistry of Newnan’s dental staff of any personal or health information changes. I further understand that this consent will remain in effect until such time that I choose it to be terminated.

________________________________________ ___________________________________
Parent/Legal Guardian Name printed Parent/Legal Guardian Signature

________________________________________ ___________________________________
Date Relationship to Patient