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
healthyteeth4kids.com

TELL US ABOUT YOUR CHILD

Name:_____

Name Called:_____

Male:☐ Female:☐ Age:_____

Child's birth date:_____ Child's SS#:_____

Other Siblings/ages:_____

School:_____

Child's Home #:_____

MOTHER OR GUARDIAN INFORMATION

Name:_____

Address:_____

City:_____ State:_____ ZIP:_____

Cell #:_____ Home#:_____

Employer:_____

Email:_____

_____

DOB:_____ SS#:_____

** Do you receive text messages?

FATHER OR GUARDIAN INFORMATION

Name:_____

Address:_____

City:_____ State:_____ ZIP:_____

Cell #:_____ Home#:_____

Employer:_____

Email:_____

_____

DOB:_____ SS#:_____

** Do you receive text messages? Y☐ N☐

Who has legal custody of this child?_____

PERSON RESPONSIBLE FOR ACCOUNT

*Responsible party is the parent/guardian who will be bringing the child to appointments most of the time.

Name:_____

Address:_____

Home#:_____ Cell #:_____

DOB_____ SS#:_____

How did you hear about us?_____

Friend? Please give name._____

Google? What word did you search?_____

Other?_____

Do you as parents have any concerns or fear about dental treatment?_____

Why did you come see us today?_____

_____

Is this your child's first dental visit?_____

Has the child ever had a serious/difficult problem with dental treatment? ☐Yes ☐No If yes, please explain:_____

_____

_____

Patient's physician?_____

Physician phone #_____

Date of last physician visit_____

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 (date)_____

Was your child bottle or breast fed?_____

Age stopped bottle or breast feeding?_____

Is your water fluoridated? ☐Yes ☐No

Does your child take fluoride supplements? ☐Yes ☐No

Is there anything else we should know about your child?

_____

_____

_____

_____

_____

_____

_____

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 _____ 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.

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 Care Credit (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

Edward C . Perdue, DDS
(615) 662-2191

MEDICAL HISTORY

Patient Name: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____
Have you ever been told by a physician that your child may need antibiotics before medical/dental procedures? ☐ Yes ☐ No
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No

Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No

Women: Are you
Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
ADHD	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach/Intestinal Disease	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No
Cold Sores/Fever Blisters	☐ Yes ☐ No	Heart Pacemaker	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	**Autism**	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No	**Downs Syndrome**	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No	**Cerebral Palsy**	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No	**Genetic Disorder**	☐ Yes ☐ No

Have you ever had any serious illness not listed above? ☐ Yes ☐ No

If yes to any above please explain: _____

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ 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 that I can understand.

I understand that I have the right to have the risks and benefits of proposed diagnostic or treatment options explained to me in a manner that I can understand, and 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 the doctors and staff will do everything possible, within the ethical constraints of densitry, 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 they should be made available to me within 14 business days.

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 concerns about my current health status.

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

I understand that it is important 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 Signature Date

Doctor Signature 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 this page thoroughly and then sign in the presence of a staff member to indicate that you understand these policies and agree to comply with them.

Commitment to Treatment Policy

We believe that all treatment begun should be completed. Incomplete treatment can lead 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. Therefor, this policy states that all agreed upon treatment plans, once they are started, will be completed.

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 patient 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 of payment for our services is yours. By signing below, you have indicated 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 has to be place with a collection agency, you agree to pay collection and attorney fees incurred to collect this account.

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 that 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 2 business days notice with 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 TNCare patients a 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 respect 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 Date Staff Member

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

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HIPAA AUTHORIZATION FORM

Patient's Full Name _____ Parent(s) Full Name _____

Address _____ Patient's Date of Birth _____

City, State Zip Code _____ Patient's Telephone Number _____

I have received the Notice of Privacy Practices for Dr. Edward Perdue. Dr. Edward Perdue may share my health information with:

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person/class of person/facility is authorized to use or disclose information about me:

   _____

2. The following person (or class of persons) may receive disclosure of protected health information about my child:

   _____
   Name

   _____
   Name

   _____
   Name

3. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

4. I may revoke this authorization by notifying Dr. Edward Perdue in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect these actions.

FEES FOR COPIES: Federal and state laws permit a fee to be charged for the copying of patient records You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING

Signature of Guardian Personal Representative	Date of Guardian's/Personal Representative's Signature	Relation to Patient
_____	_____	_____

OFFICE USE ONLY

☐ Individual refused to sign

☐ Communications barrier prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining the acknowledgement

☐ Other (please specify)_____

_____

In order to reserve your appointment time, we must have a working contact number. If we are unable to reach you to confirm an appointment, it will be cancelled and this will be considered a missed appointment. Please give all telephone numbers where you can be reached.

We must have 48 hour notice to cancel or reschedule sedation appointments, and 24 hour notice for all other appointments. There will be a $50.00 charge for missed sedation appointments and $25.00 for all other appointments. Charges will be applied to your account and must be paid before you child is rescheduled.

Signature_____

Date_____