GEORGE M. SHORT, D.D.S. • BRIAN C. SHORT, D.D.S. • DENTISTRY FOR CHILDREN • 33 STONEBRIDGE BLVD. • JACKSON, TN 38305

Date _____

I. GENERAL INFORMATION

Child's Name _____ Social Security # _____

Name child goes by _____ Sex _____ Race _____

Date of Birth _____ Age _____ Place of Birth _____

Child's Physician_____ Family Dentist _____

Father's Name or Legal Guardian _____ Social Security # _____

His Address _____ Phone No. _____
Street City State Zip

Employed by _____ Phone No. _____

Mother's Name or Legal Guardian _____ Social Security # _____

Her Address_____ Phone No. _____
Street City State Zip

Employed by _____ Phone No. _____

Who does the child live with? _____

Names and ages of brothers and sisters _____

Does your child have private dental insurance? _____ yes _____no_____ No. _____

Does your child have Tenn Care? _____ yes_____ no CoverKids ____yes ____no Headstart Program_____ yes _____no

If your child has dental Insurance and Tenn Care, it is insurance fraud if you do not inform us of your insurance coverage. It must be filed first.

Who referred you to us, so we may thank them? _____

Emergency telephone number and/or cell phone_____ Email: _____

II. CHILD'S HEALTH HISTORY

Is your child in good health? _____ yes _____ no

Is your child up to date with immunizations? _____ yes _____ no

Check any of the following that may pertain to your child:

_____	Heart Condition	_____	Rheumatic Fever	_____	Mental Disorder
_____	Liver Disorder	_____	Asthma	_____	Nervous Disorder
_____	Kidney Disorder	_____	Sickle Cell Anemia	_____	Bleeding Disorder
_____	Lung Problems	_____	Diabetes	_____	Speech Disorder
_____	Brain Damage	_____	Downs Syndrome	_____	Hearing Disorder
_____	Epilepsy	_____	Cerebral Palsy	_____	Vision Disorder
_____	Tuberculosis	_____	Autism	_____	Allergies
_____	Hepatitis	_____	Emotional Disorder	_____	AIDS
				_____	Other
				_____	HIV Positive

Is the patient pregnant? _____ yes _____ no

Is your child allergic to red dye or latex? _____ yes _____ no

Has your child ever been diagnosed with a heart murmur? _____ yes _____ no

Does the child have a medical condition where antibiotics MUST be taken before EVERY dental visit? _____yes_____ no

Is this your child's first trip to the dentist? _____ yes _____ no

Does your child suck his thumb, finger or take a pacifier? _____ yes _____ no

Does your child have a tooth that hurts now? _____ yes _____ no

Is your child presently taking any medications? (names) _____

Is your child allergic to **ANY** medications? _____ yes _____ no What? _____

Date of the child's last dental visit _____Who did they see? _____

If you are not biological parent, do you have legal custody through the court system? _____ yes _____ no

Parent that brings the child to our office is legally responsible to us for payment of the account.

X_____
Signature of person completing form

Date _____

X _____
Signature of person responsible for account

Parent or Guardian's Consent: I hereby give permission for my child to receive the routine dental treatment, which the doctor deems necessary and appropriate. Routine treatment may include, but not be limited to, topical anesthetic, intermittent radiographs, local anesthetics (injections), nitrous oxide, etc.

Signed X _____

INSURANCE INFORMATION

PRIMARY INSURANCE INFORMATION

Employee's Name/
Policyholder _____

Name of Insurance Company _____

Employer_____

Plan ID or Group No._____

Subscriber Social Security No. _____

Employee's Birthdate _____

SECONDARY INSURANCE INFORMATION

Employee's Name/
Policyholder _____

Name of Insurance Company _____

Employer_____

Plan ID or Group No._____

Subscriber Social Security No. _____

Employee's Birthdate _____

SIGNATURE ON FILE

I have reviewed and accepted the foregoing treatment plan. I authorize release of any information relating to this claim.

X_____
Signature, date

I authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me, but not to exceed the charges shown. I understand that I am financially responsible for any charges not covered by this authorization.

Should you forget to obtain a school excuse while here, do you give permission to have it faxed to your child's school?
Yes or No

X_____
Signature, date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement ***

I, X_____ , Parent or Legal Guardian of_____
have received a copy of this office's Notice of Privacy Practices.

Signature X _____ Date _____

If you are unable to bring your child to his or her appointment, who has permission to authorize dental treatment?

Name X_____ **Relationship** _____

BROKEN APPOINTMENT POLICY:

Our office does not charge for broken appointments, but after three, we may not be able to reschedule your child in this office. This does not include appointments cancelled prior to appointment time.

This policy helps us to serve you in a more timely manner and if we know in advance you are unable to keep your appointment, we are able to schedule our patients who have toothaches or other dental emergencies.

Thank you for your cooperation in this matter.

I have read the above policy.

X_____
Signature of Parent or Legal Guardian