dr. meade moore
1908 Exeter, Germantown, TN 38138
germantowndds4kids.com

Account #_____

Child's Name _____ Date of Birth ____/_____/_____

Sex: ____Male ____Female

Medical and Dental History

Please answer all questions. This information is important for assessing your child's dental needs.

1. Is your child in good health? ___Yes ___No
2. Is your child up to date with immunizations? ___Yes ___No
3. Is your child being treated for any medical condition at this time? ___Yes ___No
   If yes, what? _____
4. Is your child taking any medications? ___Yes ___No. If yes, what? _____
5. Has your child ever been hospitalized since birth? ___Yes ___No. If yes, give approximate date(s) and reason(s):
   _____
6. Is your child allergic to: Any medications? ___Yes ___No. If yes, what? _____
   Dental anesthetics (Novacaine)? ___Yes ___No
   Any food? ___Yes ___No. If yes, what? _____
   Latex? ___Yes ___No
   Other? ___Yes ___No. If yes, please explain _____

7. Please **circle** any conditions which apply to your child:

Heart Condition	Brain Injury	Fainting/Seizures/Epilepsy
Heart Murmur	Cerebral Palsy	Hyperactive/ADD
Rheumatic Fever	Spina Bifida	Depression
Artificial Heart Valves	Down's Syndrome	Blood Transfusion
Congenital Heart Defect	Autism	Surgeries/Operations
Scarlet Fever	Hearing Disorder	Seasonal Allergies
Cancer/Tumors/Leukemia	Nervous Disorder	Chemotherapy
Speech Disorder	Reflux	Respiratory Problems
Vision Disorder	Fever Blisters	Asthma
Mouth Ulcers	Diabetes/Hypoglycemia	Emotional Disorder
Hemophilia	Behavioral Problems	Sickle Cell Anemia
Abnormal Bleeding	Jaw Problems/TMJ/TMD	Sickle Cell Trait
Latex Allergy	Tuberculosis	Birth Control Pills
High/Low blood Pressure	Cleft Lip/Cleft Palate	Organ Problems
HIV+/AIDS/ARC	Mental Condition	Hepatitis

Other _____

8. Is this your child's FIRST visit to the dentist? ___Yes ___No
9. Does your child have a toothache or is he/she in pain or discomfort at this time? ___Yes ___No
10. Does your child require pre-medication? ___Yes ___No
11. Please **circle** any of the following that pertain to your child:

Grinds teeth	Bites or sucks lip	Mouth breathing/snoring
Clenches teeth	Bites nails	Sleeps with a bottle
Sucks thumb or fingers	Jaw pain	Uses "Sippy" cup
Uses a pacifier	Jaw popping	Injury to teeth/mouth/jaw/face

Parent or Guardian's Signature_____ Date___/____/_____

dr. meade moore
pediatric dentistry

Account #_____

PATIENT INFORMATION

Child's Name_____
(First) (Middle) (Last)
Date of Birth_____ Age_____ Sex _____M _____F
Street Address_____
City_____ State_____ Zip_____
Home Phone_____
Child's Physcian/Pediatrician_____
School_____ Grade_____
Other children in family who are patients in this office_____
With whom does the child live?_____
Who is accompanying patient today? _____ Do you have legal custody? _____
What phone number should we use to confirm appointment? _____
Email to be used for this account _____
Text number to use for this account _____
Referred by_____

PARENT INFORMATION

Mother's Information

Name_____
Address_____
City_____ST_____Zip_____
Home Phone (___) ____ - _____
Work (___) ____ - _____
Cell (___) ____ - _____
Date of Birth_____
SSN_____-_____-_____
Employer_____
Email_____

Father's Information

Name_____
Address_____
City_____ST_____Zip_____
Home Phone (___) ____ - _____
Work (___) ____ - _____
Cell (___) ____ - _____
Date of Birth_____
SSN_____-_____-_____
Employer_____
Email_____

DENTAL INSURANCE INFORMATION

Insurance company_____
Insurance Co. Phone_____
Insured's Name_____
Employer of Insured: _____
Group #_____
Insured's DOB_____
Insured's SSN_____
Insured's ID_____
Relationship of Insured to patient_____

Signature (Parent or Legal Guardian)_____Date_____

Consent for Treatment/Payment

As parent/guardian of this patient, I hereby authorize Dr Meade Moore and his staff to accomplish necessary dental treatment on this patient. Furthermore, I will be responsible for any bill incurred by the dental treatment of this child, including reasonable attorney's fees and costs of collection in the event of default. I understand that payment is expected at the time that services are rendered. There will be a $25 charge for all returned checks.

I authorize this office to file dental claims on my behalf. I give permission for insurance benefits to be paid directly to Dr S Meade Moore, III, DDS, MS, and authorize Dr. Moore's office to release all information necessary to secure dental benefit payments.

Signature: _____ Date:_____
(parent/guardian)

Cancellation/Broken Appointment Policy

To provide our patients with the highest level of dental care, it is important to maintain a mutual respect for your time and ours. We work diligently to see our patients at their scheduled appointment times. Many times, we have a waiting list of patients for specific appointment times. **Consequently, we request a 24-hour notice in you need to change your child's appointment for any reason.** This extra time will allow us to contact patients on that waiting list, and to schedule them for their dental treatment.

If your child fails to show-up for their appointment **without prior notice** ("No Show"), then a broken appointment fee of $50.00 may be charged.

If an appointment is cancelled without 24-hour notice AND it is not due to illness of family emergency, we reserve the right to charge the broken appointment fee as listed above.

Broken appointment fees are NOT covered by dental insurance. Multiple broken appointments may result in future dental appointments not being scheduled in advance and/or the dismissal of the patient from our practice.

Signed: _____ Date:_____
(parent/guardian)