Southern Dental Associates
Welcome to Our Office

We would like to take this opportunity to thank you for choosing our practice to care for your child's dental needs. Our mission is to provide you with the highest quality dental care. The following office policies are in place so that we can best meet all of our patient's needs. If you have any questions or concerns, please let us know.

SAFETY AND PATIENT MANAGEMENT: Our goal is to make your child's appointment a positive experience for them by helping them to learn about dentistry while establishing a bond with our doctor and staff. Therefore, we welcome parents back for their child(ren)'s cleaning appointment(s). However, if a patient is in need of any dental treatment other than routine cleanings and exams, **only** the patient receiving dental work will be allowed in the treatment area unless otherwise discussed with the doctor. This policy has been made because of safety guidelines, infection control procedures, and better cooperation from our patients. Parents will need to wait in our waiting area until the assistant calls them to the operative room after treatment has been completed.

BROKEN APPOINTMENTS AND CANCELLATIONS: Broken appointments are a disappointment to our office and affect our schedule. So please make your appointment a priority for the well being of your child(ren) and our staff. As a courtesy to you, we offer confirmations via email or a text message can be sent directly to your cell phone. However, **it is your responsibility to contact our office the week prior to your child(ren)'s dental appointment(s) to confirm**. If we are unable to reach you to confirm an appointment, or you do not contact our office in the allowed time limitation, your child(ren)'s appointment(s) may be canceled and/or given to another patient in need of treatment.

If you are unable to keep your child(ren)'s appointment(s), you will need to contact us at least **48** hours in advance. If you cancel with less than **48** hours notice, this counts as a broken appointment. If you simply miss your appointment without notice this will also count as a broken appointment and repeated broken appointments will result in dismissal from the practice.

It is also your responsibility to contact our office if there are any changes in your contact information. Should your phone number or address change you will need to contact our office so we can update your child(ren) file(s).

If your child is sick (runny nose, stuffy nose, cough, congestion, sore throat, fever, etc.), other than a dental related issue, your child needs to be seen by their medical doctor, and we will not be able to see them for any scheduled dental treatment until they are well and symptom free. If a patient becomes sick, you will still need to call our office, within the required time limitations, to cancel their appointment. Again, if you do not provide us with proper notice, we may not be able to reschedule your child(ren)'s appointment(s). As a courtesy to our staff and our other patients, **please do not bring a sick child into our office**.

CONSENT: By signing below, I authorize the doctor and our office staff to perform diagnostic procedures and treatment, which may be necessary for proper dental care, release necessary information to the insurance company for claims, release information to another dentist, and authorize insurance payment directly to this practice. I understand that I am financially responsible for payment in full of treatment not covered by Medicaid, such as and not limited to indirect/direct pulp caps/therapy, in-office sedation, re-cementation of space maintainers and/or crowns, or orthodontic treatment.

Patient's Name:_______________________________ Date:____________

Signature of Parent/Guardian:_______________________________________

MEDICAL HISTORY

PATIENT INFORMATION

Patient Name______________________________________ Birth Date _________ SSN _________________________
Name your child wishes to be called _________________ Sex ▪F ▪M Age ______
Address ____ Home Phone _____________________________________
____ Child's School ____________________ Grade_________
Siblings ____

FAMILY INFORMATION

Who referred you to the office?____
Have any members of your family been seen in our office? ______________________________

Mother's Name:____________________________________ Birth Date _________ SSN _________________________
Address: ____ Home Phone ______________________________________
____ Cell Phone____
____ Employer____
Email: ____ Employer Phone ___________________________________
Father's Name: ____________________________________ Birth Date _________ SSN _________________________
Address: ____ Home Phone ______________________________________
____ Cell Phone____
____ Employer____
Email: ____ Employer Phone ___________________________________
Child resides with: ▪ Mother ▪ Father ▪ Both Parents ▪ other _______________________________________
Address ____ Home Phone ______________________________________
____ Employer____
____ Employer Phone___________________________________

Person responsible for payment on account
____

Note: If a person is not specified above, the person who brings the child to their initial visit will be listed as the Guarantor on the account. All correspondence will be addressed and mailed to the person listed as the Guarantor. If a family member is already listed in our system we will add the patient to the existing account unless we are instructed otherwise

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HEALTH HISTORY

Who is your child's pediatrician/medical doctor? ______________________________Phone____________________________
Has your child ever been hospitalized? Yes No
If so, give reason.____
Does your child have any allergies to medications or substances? Yes No
If so, please list.____
Does your child have any other allergies? Yes No
Is your child currently taking any medications or substances? Yes No
If so, please list. ____

Does your child have or has your child ever had any of the following?

Rheumatic Fever	Yes	No	Leukemia	Yes	No	Heart Disease	Yes	No
Diabetes	Yes	No	Heart Murmur	Yes	No	AIDS	Yes	No
Anemia	Yes	No	HIV Positive	Yes	No	Hemophilia	Yes	No
Hepatitis	Yes	No	Asthma	Yes	No	Tuberculosis	Yes	No
Epilepsy	Yes	No	Cleft Lip/Palate	Yes	No	Other Seizures	Yes	No

Please describe any of the above conditions that you have stated "yes" to:
____
Does your child have any disease, condition or problem not listed?

DENTAL HISTORY

Has your child ever been to the dentist? Yes No Name and date ______________________________

How long since last visit? ______________________________

How often does your child brush their teeth? ____________ Are you helping your child brush and floss? ____________

What does your child snack on throughout the day? ______________________________

What does your child drink throughout the day? ______________________________

Does your child suck a finger, thumb or pacifier? Yes No

Are you aware of any particular problems? ______________________________

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How do you feel about your child's teeth in general? ______________________________

____

Comments: ______________________________

FLOURIDE HISTORY

Do you have city water? Yes No If No, what is your source of water: ______________________________

Does your child use fluoride toothpaste? Yes No

Do you give your child any other form of fluoride? Yes No What type ______________________________

Does your child participate in a school fluoride rinse program? Yes No

Would you like to speak to the dentist privately about any problem? Yes No

In regards to the learning process, do you consider your child: · advanced · progressing normally · slow

Was your child: · breast fed · bottle fed · both at what age was it stopped? ______________________________

I certify that the above information is complete and accurate to the best of my knowledge.

Parent/Guardian's Signature______________________________