

Medical History

Date of Last Exam _____ Findings _____

Is child under care of Physician now? Yes No Medications _____

Receiving any medications or drugs? Yes No _____

Ever been hospitalized? Yes No _____

Ever had surgery? Yes No Drug Allergies _____

Is there excessive bleeding when cut? Yes No _____

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES PLEASE CHECK (X)

- AIDS/HIV Chicken Pox Fainting Liver Disease Thyroid Disease
- Anemia Convulsions Hearing Problems Measles Tuberculosis
- Asthma Developmental Delay Heart Murmur Mononucleosis Other
- Bladder Problems Diabetes Heart Problems Mumps Seasonal Allergies
- Cancer Drug/Alcohol Abuse Hepatitis Rheumatic Fever
- Cerebral Palsy Epilepsy Kidney Disease Sinus Problems

In the event of an emergency, whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Authorization

The information I have given is correct to best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child medical status. I authorize the dental staff to perform the necessary dental services to my minor/child.

Signature of Parent/Guardian Date

I certify that I am covered by insurance with _____
(Name of Insurance Company)

and assign directly to Dr. Freeman all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Parent/Guardian Date



Practice Financial Policy

We are committed to providing your child with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial and insurance policies is important to our professional relationship.

- All patients must complete the Patient Information & Medical Form before seeing the Doctor.
- Full payment is due at the time of the service unless other arrangements are made.
- Twenty-four hour notice is required when re-scheduling or canceling appointment.
- For your convenience, we accept CASH, PERSONAL CHECKS, ATM DEBIT PAYMENTS, VISA, and MC.
- In addition, we offer third party Financing with a convenient monthly payment plan for larger balances.
- Interest of 18% will begin accrue on balances over 60 days.
- I understand it is my full financial responsibility to pay all court cost, all collection fees and/or attorney fees if my account is turned over for collections

As a convenience to you, we will be happy to submit your insurance claims. The insurance company, not our office, determines the dental benefits that you will receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment, insurance coverage, etc.

The adult accompanying a minor and/or the parent (or guardian of the minor) is responsible for payment at the time of appointment.

Signature

Date



Daniel Freeman, DDS
Pediatric Dentistry

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**ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this office's Notice of Privacy Practices.

Name (Please Print) _____

Signature _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

Name (Please Print) _____

Signature _____

Date _____