F. William Taylor, DDS, MS, PC

Diplomate of American Board of Pediatric Dentistry

Dentistry for Kids, Teens and Those with Special Needs
(615) 824-1700 www.Just4KidsTeeth.com

TELL US ABOUT YOUR CHILD

Name: ______
Name Called: ______
Male: ______ Female: ______ Age: ______
Child's date of birth: ______
Other Siblings/Ages: ______
School: ______
Child's Home #: ______

MOTHER'S INFORMATION

Name: ______
Address: ______
______
Home#: ______ Cell#: ______
Employer: ______
Work #: ______
Email Address: ______
SS# ______ **DL#** ______

FATHER'S INFORMATION

Name: ______
Address: ______
______
Home#: ______ Cell#: ______
Employer: ______
Work #: ______
Email Address: ______
SS# ______ **DL#** ______

Who has legal custody of this child? ______

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS

____heart murmur ____congenital heart defect
____rheumatic fever ____anemia
____hepatitis ____convulsions
____mental retardation ____Downs Syndrome
____cleft lip/palate ____eye problems
____tuberculosis ____diabetes
____asthma ____HIV/AIDS
____blood transfusions date ______
____bleeding ____epilepsy
____herpes/cold sores ____cerebral palsy
____liver/kidney ____speech/hearing
____autism ____fainting
____emotional, mental, nervous disorder

Other ______

Who may we thank for referring you? ______
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: ______
Please list all drugs to which the child is **allergic**: ______
______
Is the child presently under the care of a physician?
Yes No If yes, please explain ______
______
Please list all drugs that the child is currently taking: ______
______
______

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? ______
Does your child take fluoride supplements? ______

PERSON RESPONSIBLE FOR ACCOUNT

Name: ______
Billing address: ______
______
Cell #: ______ Home#: ______
How do you prefer to pay: ____ Cash ______Check
____Care Credit # ______
____MC/VISA/AMEX/DISCOVER # ______
SS#: ______

Nearest relative not living with you: ______
Phone: ______
Address: ______
______

TennCare: Yes No # ______

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Ins. Co. Name:______________________________	Ins. Co. Name:______________________________
Address:__________________________________	Address:__________________________________
____	____
Phone # :__________________________________	Phone # :__________________________________
Group #:________________ Policy #__________	Group #:________________ Policy #__________
Insured's ID #:_____________________________	Insured's ID #:_____________________________
Relationship to patient:______________________	Relationship to patient:______________________
Insured's date of birth:______________________	Insured's date of birth:______________________
Insured's SS#:_____________________________	Insured's SS#:_____________________________
Insured's Employer:_________________________	Insured's Employer:_________________________

GUARDIAN & FINANCIAL INFORMATION

Dr. F. William Taylor and his staff are committed to providing your child with the best possible care. Dr. Taylor 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. Taylor and/or associates. Authorization is granted by signing below.

If you have dental 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 will pay 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, American Express 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 3% 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. Taylor and associates to perform dental services for my child.

Guardian______________________________Date____________________Relationship____________________

Guardian______________________________Date____________________Relationship____________________

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 that 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 leads 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. Therefore, 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, skill and judgment in planning for your dental treatment. Our office operates on a fee-for-service basis. For patients without dental insurance we accept MasterCard, Visa, Discover, American Express and CareCredit 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 principle.

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. 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. If it should happen that you arrive late for your reserved appointment, please understand that we may not be able to see your child on that day. Due to the limited availability of our sedation time, a fee may be charged for broken sedation appointments. We reserve the right to charge a fee and/or dismiss the patient from our practice for excessively missed appointments.

We appreciate your cooperation with these scheduling policies. Helping Dr. Taylor 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 Date

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I, ________________________ legal guardian of ______________________, have

(Please Print Guardian Name) (Please Print Patient Name)

received a copy of this office's Notice of Privacy Practices.

____

(Signature)

____

(Date)

For Office Use Only

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

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

____

____

____

Please list names of all persons with whom Dr. F. William Taylor's staff may discuss your child's treatment and or other dental needs.

Person	Relationship
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________