

DENTISTRY FOR CHILDREN & TEENS
2244 Henderson Mill Road, Suite 300, Atlanta, Georgia 30345
WESLEY D. POWELL, D.D.S., M.S.

WELCOME AND THANK YOU FOR SELECTING US!

PATIENT INFORMATION:

Name: (First) _____ (Middle Initial) _____ (Last) _____

Nickname: _____ Sex: M F Birthdate: ____/____/____ Age: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Tel #: (____) _____

SS#: _____ Name/s of siblings seen in this office: _____

How did you find our practice? _____

PARENT/GUARDIAN INFORMATION:

Mother's Name: _____ Email Address: _____

Street Address: _____

City/State/Zip: _____ Birthdate: ____/____/____

Employer _____ Occupation: _____

Driver's License: _____ Social Security #: _____

Home Phone #: _____ Work Phone #: _____ Cell #: _____

Father's Name: _____ Email Address: _____

Street Address: _____

City/Sate/Zip: _____ Birthdate: ____/____/____

Employer _____ Occupation: _____

Driver's License: _____ Social Security #: _____

Home Phone #: _____ Work Phone: _____ Cell #: _____

MEDICAL/DENTAL HISTORY

Has your child ever had any of the following: **Please mark "Y" for YES and "N" for NO for EACH ITEM.**

- | | |
|--|--|
| <input type="checkbox"/> ALLERGIES | <input type="checkbox"/> PHYSICAL OR MENTAL DISABILITIES |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> CONGENITAL HEART DEFECT |
| <input type="checkbox"/> FEBRILE SEIZURES | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> SEIZURES W/O FEVER | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> BLOOD TRANSFUSIONS | <input type="checkbox"/> STOMACH/LIVER/KIDNEY PROBLEMS |
| <input type="checkbox"/> HEMOPHILIA | <input type="checkbox"/> ABNORMAL BLEEDING |
| <input type="checkbox"/> HEPATITIS/JAUNDICE | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ENLARGED ADENOIDS/TONSILS | <input type="checkbox"/> ASTHMA |
| <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> FREQUENT MIDDLE EAR INFECTIONS |
| <input type="checkbox"/> LEARNING DIFFERENCES | <input type="checkbox"/> SPEECH PROBLEMS |

If marked Y, please explain _____
Does your child have any allergies/sensitivities/adverse reactions to any drugs or medications? _____
Has your child ever taken Penicillin? _____ Has your child ever been hospitalized? _____
Why? _____
Has your child ever had surgery? _____ Type of surgery: _____
Why? _____
Please explain any medical problems or conditions that your child has, which have not been listed previously: _____

CURRENT MEDICATIONS: _____

TREATMENT FOR: _____

Does your child have any learning/behavior issues that we should be aware of, so that we may provide proper treatment? _____

Date of last dental visit: _____ Reason: _____
Any current dental problems? _____
Does your child suck his/her thumb/finger/pacifier? _____
Does your child mouthbreathe during the day? _____
Is fluoride taken in any form? _____
Has your child ever had an unhappy dental experience? _____
Has your child had any injuries to the mouth/head/teeth? _____

Please evaluate and check your expectations for your child's care.
 Treatment of pain Orthodontics, if necessary Treatment of decay
 Esthetics (to improve cosmetics) Fear control Teeth whitening
 Maintain oral health

PEDIATRICIAN'S NAME: _____ **PHONE#** _____

PREVIOUS DENTIST: _____ **PHONE#** _____

TIME IS OF VALUE

Since we limit our practice to children and adolescents we clearly are unable to see all patients in the afternoon. Certain types of appointments must be made during the morning hours. It is important for us to reserve enough time for the treatment of our patients. We expect this reserved time to be a priority with the patient also. There will be a \$45 charge for each broken or cancelled appointment without a 2 business day notice. Your cooperation is greatly appreciated.

SIGNATURE _____ **DATE** _____

We make every effort to stay on schedule. Please be understanding if you experience a delay. Occasionally there are emergencies that cannot wait. Each child is given the individual attention needed for each visit. Please be patient and know that your child will be receiving the same care.

**For your convenience, we accept cash or credit card payment.
We appreciate payment in full the day services are rendered.
We DO NOT accept personal checks.**

PRIMARY INSURANCE INFORMATION

Insured's Name _____ Relationship to patient _____
Insured's Birthdate _____ Social Security # _____
Employer _____
ID # _____ Group # _____
Insurance Company _____
Street Address/PO Box _____
City, State, Zip _____

WE DO NOT FILE TO YOUR SECONDARY INSURANCE, IF YOU HAVE ONE.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any change in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I agree to be responsible for payment of all services rendered.

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP TO PATIENT: _____

DENTISTRY FOR CHILDREN AND TEENS

Wesley D. Powell, D.D.S., M.S.

Pediatric Dentistry Specialty

OFFICE POLICY

Dr. Wesley Powell is considered a SPECIALIST. As he is highly trained to care for children, our fees are not comparable to either a family or general dentistry practice.

We are a participating provider with Aetna PPO, MetLife PPO and Cigna PPO. For dental plans we are NOT contracted with, we extend the courtesy of filing the visit and the procedures to your insurance company. We require a portion of the charges (20% to 30% for hygiene and 50% for treatment) be paid at the time of service regardless of what your coverage is. THE MONIES COLLECTED ARE ESTIMATES. If a credit is left after insurance payment, we either issue a refund check or apply the credit to your next visit. Although we are pleased to provide such a service to our patients, it is impossible for our office staff to be aware of the specific requirements and limitations of each and every plan. Verification of coverage IS NOT a guarantee of payment.

Our primary concern is providing the best quality dental care to our patients. However, it is your responsibility to inform our staff of guidelines set by your insurance company. We will gladly work within those guidelines. Unfortunately, if you do not inform us and we subsequently performed services and/or procedures, the office IS NOT liable for it. **PAYMENT OF THESE SERVICES WILL BECOME YOUR RESPONSIBILITY.** Furthermore, as a non-participating provider, we do not make any fee adjustment or write off.

If for some reason a parent is not able to bring the child, we need a signed authorization from the parent/guarantor allowing us to do dental care on the child. Please let us know how to contact you in case we have any questions.

With your cooperation to provide us the necessary information regarding your dental plan, we, at Dentistry for Children and Teens, can focus on the dental needs of our patients.

I have read and understand the above office policy and agree to accept responsibility as described.

Name/s of Patient/s: _____

Signature:

Parent/Guarantor _____ Date: _____