Pediatric Dental Centers, PC
601 N. W. Atlantic Street Street, Suite A Tullahoma, TN 37388
Office 931-455-8003 , 931-455-8348

Child's full name_____ Child's nickname_____
Sex: M_____ F_____ Date of Birth (DOB) _____Child's SS#_____
Child's primary address_____**city**_____**state** ____**zip**_____
phone #'s : home_(____)_____ mom cell (___)_____dad cell (___)_____other(____)_____
Names of siblings we see in our practice_____

Father/Guardian's full name_____DOB_____SS#_____ marital status ☐M ☐S ☐W ☐D
Address if different from above_____city_____state ____zip_____
Employer:_____work (___)_____ can we contact you at work? yes____ no_____

Mother/Guardian's full name_____DOB_____SS#_____marital status ☐M ☐S ☐W ☐D
Address if different from above_____city_____state ____zip_____
Employer:_____work (___)_____ can we contact you at work ? yes____ no____

Who has custody? Both☐ Father☐ Mother☐ Grandparent (names)_____
Are you a foster parent? _____ if so under which Dept of Children Services?_____
Names of those authorized to bring this minor for their dental appointments_____
_____
Emergency contact not living with you : Name_____phone #_____

Dental Insurance information:
Primary Insurance:
Policy Holder/Subscriber: Name as appears on card_____Subscriber SS#_____
Subscriber Date of Birth_____ Employer _____Name of insurance Co._____
Secondary Insurance:
Policy Holder/Subscriber: Name as appears on card_____Subscriber SS#_____
Subscriber Date of Birth_____ Employer _____Name of insurance Co._____

Assignment of Benefits: I authorize you to furnish my insurance company with all information to process my dental claims I authorize my insurance company to explain my insurance benefits to you, and to pay all benefits due me directly to Pediatric Dental Centers, PC. I understand I am financially responsible for charges not covered by my insurance company plan, this includes Tenn-dent and Cover-kids.

Informed Consent: As parent or legal guardian I give my informed consent for this minor to receive any and all exam and dental treatment deemed necessary, including, but not limited to: administration of anesthesia, radiographs, fluoride treatments, sealants, dental extractions, and/or restorations. I understand I may have any questions answered regarding my child's treatment.

Financial liability: I understand I am financially responsible for any deductible(s), co-insurance(s) or any and all charges not covered by my insurance company. Payment is due and payable on date of service. I understand most medical insurance companies do not cover dental treatment. I understand that most insurance policies do not cover the total cost of treatment. If debts are outstanding, the debtor agrees to pay all collection costs, reasonable attorney's fees and late fees, returned check fee, etc and agrees that the debt is due and payable in Tullahoma, Coffee Co., TN.

Medical updates: I understand that I am legally responsible for informing Pediatric Dental Centers, PC and their associates of any and all changes in my child's medical/dental health.

Signature_____ **Date**_____
Relationship to child_____