Welcome

Patient ID # _____ Today's Date _____

to our practice! We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____

Nickname _____ Sex _____

Birthdate _____ Age _____

SS#/SIN _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Phone _____

Responsible Party

Name _____

Relationship _____

Address _____

City _____ State/Prov. _____ Zip/P.C. _____

Email _____

SS#/SIN _____

DL # _____

Who is responsible for making appointments?

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Best time to call _____

Time _____ Days _____

Mother ☐ Stepmother ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Father ☐ Stepfather ☐ Guardian

Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Ext. _____

Email _____

Employer _____

Occupation _____

SS#/SIN _____

DL # _____

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Primary Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____

Amount already used _____

Max. annual benefit _____

Additional Insurance

Insured's Name _____

Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____

Occupation _____

Insurance Company _____

Group # _____ Employee # _____

Ins. Co. address _____

City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____

Amount already used _____

Max. annual benefit _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

Payment in full at each appointment. ☐ Cash ☐ Personal Check

Credit Card ☐ Visa ☐ MC ☐ I wish to discuss the office's payment policy.

Dental & Health History *CONFIDENTIAL* Patient ID # _____

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____ How often does your child floss? _____

Is your child's water fluoridated? ☐ Yes ☐ No Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck thumb/finger ☐ Yes ☐ No Chew hard objects (pencils, etc.) ☐ Yes ☐ No

Suck/Bite lip ☐ Yes ☐ No Grind teeth ☐ Yes ☐ No

Bite/Chew nails? ☐ Yes ☐ No Clench jaws ☐ Yes ☐ No

Previous dentist _____ Address _____

Date of last dental visit? _____ _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Child's physician _____ Address _____

Phone # _____ _____

Previous Hospitalizations/Surgeries/Serious Illnesses? When?

_____ _____

_____ _____

_____ _____

Is your child currently taking medications? ☐ Yes ☐ No (if yes, please list)

_____

Has your child ever taken Fen-Phen/Redux? ☐ Yes ☐ No

_____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (penicillin, Novocain, etc.)? ☐ Yes ☐ No (if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)?

_____

Has your child ever had any of the following:

Asthma ☐ Yes ☐ No Stomach, liver or kidney problems ☐ Yes ☐ No

Cancer ☐ Yes ☐ No Handicaps/Disabilities ☐ Yes ☐ No

Hepatitis ☐ Yes ☐ No Tuberculosis ☐ Yes ☐ No

HIV/AIDS ☐ Yes ☐ No Diabetes ☐ Yes ☐ No

Hemophilia ☐ Yes ☐ No Rheumatic Fever ☐ Yes ☐ No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) ☐ Yes ☐ No Congenital Heart Defect ☐ Yes ☐ No

Heart Murmur ☐ Yes ☐ No

Abnormal Bleeding ☐ Yes ☐ No Convulsions/Epilepsy ☐ Yes ☐ No

Please explain any medical problems that your child has: _____

_____

Authorization & Release

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 changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need.

I also authorize the Dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dentist or Dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of patient (or parent/guardian if minor) Date

Dentist Review:

_____ _____

Signature of Dentist Date

Winterville Dental, LLC

Phillip H. Durden, DMD, MAGD, FAACP • Brandon W. Whitworth, DMD • Chase M. Wootton, DMD, FAGD • Robert T. Hardell, Jr., DMD

104 Moores Grove Road • Winterville, Georgia 30683 • Phone 706.742.7000

Medication List

If your child is taking any prescribed medications, OTC medications, herbal supplements or vitamins, please complete this form.

My Child's Name is:_____

My Name is: _____

My Child's Healthcare Provider's Name is: _____

My Child's Healthcare Provider's Phone Number is:_____

My child is currently taking the following:

Medication/Supplement	When my child takes it	Dose	Other Instructions

☐ I have no medications to list at this time.

_____Date: _____

Signature of patient (or parent/guardian if minor or dependent)

WINTERVILLE DENTAL, LLC

PHILLIP H. DURDEN, DMD, MAGD, FAACP · BRANDON W. WHITWORTH, DMD · CHASE M. WOOTTON, DMD, FAGD · ROBERT T. HARDELL, JR., DMD

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name:_____

Address:_____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT-PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Sarah Strickland

Telephone: (706) 742-7000

Address: 104 Moores Grove Road, Winterville, Georgia 30683

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Winterville Dental, LLC

Phillip H. Durden, DMD, MAGD, FAACP • Brandon W. Whitworth, DMD • Chase M. Wootton, DMD, FAGD • Robert T. Hardell, Jr., DMD

If we may contact you by e-mail please provide us with your address _____

May we confirm your appointments with text messaging? Y or N

Express prior consent to contact consumber by cell phone:
You agree, in order for us to service your account or to collect monies you may owe, Winterville Dental, LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/We have read this disclosure and agree that Winterville Dental, LLC, its employees and /or agents may contact me/us as described above.

_____Date: _____
Signature of patient (or parent/guardian if minor or dependent)

_____Date: _____
Signature of dentist

PHOTOGRAPHY AGREEMENT

Dear Patient:

Dr. Durden, Dr. Whitworth, Dr. Wootton and Dr. Hardell often take photographs for the purposes of case documentation, laboratory communication, continuing education lectures, PowerPoint slide presentations, in-office communication, and for various dental and/or other articles or publications.

I hereby grant permission the use of any and all photography and x-rays of (or minor child/children)

_____ to Winterville Dental, LLC for the purposes stated above. I also acknowledge that this is done voluntarily and without compensation.

_____Date: _____
Signature of patient (or parent/guardian if minor or dependent)

104 Moores Grove Road • Winterville, Georgia 30683
Phone 706.742.7000 • Fax 706.742.2145 • WintervilleDental.com