HIGGSPEDIATRIC DENTISTRY
W. Clark Higgs. DDS

85 Cude Lane, Ste 4 Madison, TN 37115 615-859-2000 Higgspediatricdentistry.com

New Patient Registration

Child's Name ____ Name your child goes by __________________________
(First) (Middle) (Last)

Child's Age __________ Date of Birth: ___________________________ Male ( ) Female ( )

Child's Insurance _______________________________________Child's Social Security # ____________________________

Child's Address ________________________________Apt. _____ City _______________ State ________ Zip _______

Child's School ____ Grade Level ________________________________

Child's Physician or Pediatrician ____
(Name) (Address) (Phone)

Whom may we thank for referring you to this office? ____

Parent Information

Parent(s) Are: Married ________ Separated _______ Divorced _______ Widowed _______ Single _________

If divorced or separated, who has custody of the child? ____

If divorced or separated, does the non-custodial parent have obligations to the child's dental treatment? Yes _____ No _____

Father's Name _____________________________________ **Mother's Name** _____________________________________
Or Guardian (First) (Middle) (Last) **Or Guardian** (First) (Middle) (Last)

Address ___________________________________Apt. ____ Address _____________________________________Apt. ____

City ________________ State ___________ Zip ____________ City _______________ State ___________ Zip ______________

Home Phone _______________ Cell Phone _________________ Home Phone _______________ Cell Phone __________________

Work Phone _______________ Email Address ______________ Work Phone _______________ Email Address ________________

Employer ____ Employer ____

Occupation ____ Occupation ____

Social Security # ____________________________________ Social Security # _____________________________________

Date of Birth _______________________________________ Date of Birth ____

Insurance ____ Insurance ____

Person(s) responsible for payment of the account.____

If responsible partyis not listed above, give name, address, and phone numbers ___________________________________

____

OVER

Medical History

Please indicate if your child has a history of, difficulty with or diagnosed with any of the following: (Check all that apply)

___ Allergies /Chronic Sinusitis ___ Cancer ___ Headaches ___ Mental Handicap
___ AIDS or HIV ___ Cleft Palate ___ Hearing Problems ___ Mononucleosis
___ Asthma ___ Cerebral Palsy ___ Hepatitis ___ Mumps
___ Anemia ___ Chicken Pox ___ Immunizations ___ Physical Handicap
___ Arthritis ___ Cold Sores ___ Kidney ___ Seizures
___ Autism ___ Delayed Development, Growth ___ Latex Allergy ___ Sickle Cell
___ Bladder ___ Diabetes ___ Liver ___ Speech Problems
___ Bleeding Disorder ___ Epilepsy ___ Measles ___ Thyroid
___ Bone Disorder ___ Fainting ___ Medication Allergy ___ Tuberculosis
___Sulfa Allergy ___ Latex Allergy ___Metals Allergy ___Aspirin Allergy
___Allergy to Dental Anesthetics (Epinephrine, Lidocaine, Procaine, etc.) ___Food Allergies
___ Heart Ailment or Murmur – Type if know: _______________ Is your child under the care of a cardiologist or special physician for the problem? _____ If so, whom, address, & phone ____
Other condition, Please list.____
Please comment on any problem checked in the above area. ____
____
____
Please list any medication your child is currently taking and reason why. ____
____

Dental History

YES NO
( ) ( ) Is this your child's first visit to the dentist? If not, when was the last visit and what was done for your child? _________
____

( ) ( ) Has your child had an unfavorable visit with a dentist or doctor. If yes, please explain.______________________________
____
( ) ( ) Does your child take fluoride tablets, drops, or vitamins with fluoride?
( ) ( ) Does your child brush teeth daily? If no, how often does your child brush?____
( ) ( ) Do you assist your child with brushing?
( ) ( ) Does your child floss teeth daily? If no, how often does your child floss?____
( ) ( ) Do you assist your child with flossing?
( ) ( ) Does your child go to bed with a bottle or sippy cup.
( ) ( ) Have you noticed any speech problems with your child?
( ) ( ) Has your child bumped any teeth? If so, when? ____
( ) ( ) Does your child have any of the following habits?

___ Thumb Sucking How Long? ___________ Still Active? ( ) Yes ( ) No
___ Finger Habit How Long? ___________ Still Active? ( ) Yes ( ) No
___ Pacifier How Long? ___________ Still Active? ( ) Yes ( ) No

Does your child have any other mouth habits? ____

Has your child ever had a reaction to dental anesthetic? ____

Does your child have a dental problem that you are especially concerned? _______If yes, what is the concern? ________________
____

Is there any other concern you would like the dentist to address on your visit today? ____
____

This is to certify that I, the undersigned, consent to the performance of any and all procedures, and the use of any and all medications that are necessary or advisable. I agree to full responsibility for the payment of all fees associated with those services or medications. I understand that the insurance is my responsibility and may not pay as estimated. I understand that payment is due at the time of treatment. If my account requires collection services, I agree to pay all cost incurred in the collection of those fees, including collection agency fees, attorney fees, court costs, and interest that may accrue on my account. I authorize the release of information needed by my insurance company to process claims and request that payment be made by my primary/secondary insurance directly to the dentist.

Date__________________

Parent / Guardian Signature ____

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Financial Policy

As a courtesy we will file up to the maximum of two dental policies. Please be aware that we do not file medical, supplemental or any non-dental indemnity policies regardless of circumstance. (i.e.: accident, emergency) We will gladly supply the necessary documents or receipts for policies of such should you request them. This office will **not** participate in any civil matters including but not limited to divorce, legal guardianship or any other matter in which custody or financial responsibilities of a minor is in question.

We will attempt to verify your eligibility and benefits with your insurance prior to any service our office renders. We do not "bill" for services and payment is expected at time of service based on the *estimate* given to you by our office. An *estimate* is in no way a guarantee by the office of W. Clark Higgs D.D.S. that your insurance will cover the services rendered. Any quote of benefits and/or eligibility by your insurance company is not a guarantee of payment or coverage as stated in your insurance disclaimer policy.

In the event we file a claim on your behalf and your insurance has not responded within 45 days, the balance then becomes your responsibility and payment is expected accordingly. In the event your account becomes delinquent for non-payment, the account will then be turned over to a collection service and additional fees up to 50% of balance owed will apply. Court cost and attorney fees will apply if these services are required.

No Insurance= Full Payment

If you are uninsured or we are unable to verify coverage and/or benefits, payment is expected in full at time of service. See below for payment options.

Payment Options:

1. Cash
2. Money orders and personal checks **(a $35.00 fee will apply to all returned items)**
3. Visa and MasterCard
4. Care Credit-Financing made available through Care Credit. See the receptionist for further details or visit www.carecredit.com

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Appointment Policy

Thank you for allowing us the privilege of being your child's dental health provider. Our practice is dedicated to quality care and is pleased to reserve time exclusively for your child. Please read each section to this policy. If you should have any questions regarding our appointment policy, please contact the office manager at the number above.

Scheduling:

Special needs, conscious sedation and children under the age of six (6) will be scheduled in the morning. It has been proven that these children have a better dental experience during this time. Exceptions to this will be made by Dr. Higgs only.

All appointments require 24 hour cancellation notice.

If you are going to be late to your child's scheduled appointment, please be courteous and notify our office as soon as possible. You may be asked to reschedule the appointment or possibly experience a longer than normal wait time.

Children under the age of 18 must be accompanied by a parent or legal guardian.

Broken Appointments:

Broken appointments can result in dismissal from the practice and will be at the discretion of Dr. Higgs. Broken appointments are defined below:

1. Cancellation of appointment with less than 24 hour notice
2. No Show appointments
3. Multiple tardiness to scheduled appointments

In the event your child is dismissed from the practice, a letter notifying you of this will be sent via certified mail. We will see your child for thirty (30) days from date of the dismissal letter for emergencies only.
Any exceptions to this policy will be made by Dr. Higgs on an individual basis.

Electronic Appointment Confirmation:

We use an electronic appointment confirmation system, how do you wish to be sent reminders? Please Circle

Email address: ____Opt in Opt out

Text messages: ____Opt in Opt out

Phone calls: ____Opt in Opt out

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Acknowledgement of Financial & Appointment Policy

By signing below, you acknowledge that you have read and received a copy of **Higgs Pediatric Dentistry, W. Clark Higgs D.D.S.** appointment and financial policies. In addition, by signing, you agree to comply with the guidelines set forth in these policies.

Print Name (parent/legal guardian) ____

Sign Name (parent/legal guardian) ____

Date ____

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL MEDICAL – DENTAL RECORDS AND BILLING INFORMATION

I hereby request and authorize Dr. W. Clark Higgs to release and furnish to any Doctor, Hospital, Dental or Medical Related Institution or Personnel, Insurance Company or Personnel, Authorized Attorney, Billing and Collection Service, Non-Custodial Parent, any and all information including charting records, x-rays, models, lab reports and other related reports, operative notes, diagnosis and prognosis, and account records in his possession regarding me, my spouse or my child.

I understand that the release of any of the stated physical or written material is released in a way to protect personal health information and personal information. I understand that a reasonable charge, not to exceed the regulated amount set forth by the Tennessee Board of Dentistry, *may* accrue to my account and/or will be billed to me for copies of stated material and preparation of written reports, and I am responsible for payment of all such charges.

Signature ____

Relationship to the Patient _______________________________

Date ____

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ACKNOWLEDGEMENT OF HIPAA POLICIES

****You May Refuse to Sign This Acknowledgement****

I,___________________________________, have read a copy of W. Clark Higgs, D.D.S HIPAA Policies.

____

Please Print Your Name Relationship To Patient

____

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
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

Account Name: ____________________________ Account Number: _________________________________

Designation for Another Person to Transport Child Consent Form

I, (____________________________), cannot accompany my child, (________________________________)
(Parent/Legal Guardian) *(Child's Name)*

to Higgs Pediatric Dentistry. Therefore, I give permission to (______________________________)
(Person's Name that is bringing my child)
to bring my child for their dental treatment as follows (please check one):

________ I give permission for Higgs Pediatric Dentistry to provide scheduled dental treatment and I give consent for such treatment without having to contact me.

OR

________My child is old enough to drive him or herself to the office of Higgs Pediatric Dentistry. I give permission for Higgs Pediatric Dentistry to provide scheduled dental treatment and I give consent for such treatment without having to contact me.

Expiration of Permission (please check one):

______ This form will remain in effect until revoked by filling out a new form.

______ This form is VALID ONLY during the following timeframe:

Effective date: ___________ / Expiration date: ____________

X ____/________/________:_______am/pm
(Signature of parent or legal guardian) (Date and time signed-required)

X____/________/________:_______am/pm
(Signature of witness – 18 years of age or older) (Date and time signed-required)

Home Phone: ___________________________ Work Phone: _____________________________________

Cell Phone: ____

Email Address: ____