

Dentistry For Kids

Pediatric Dentists On Staff

Thomas W. Jackson, DMD – Matthew J. Price, DDS-Katie L. Hoak, DDS

General Dentists On Staff

Allison B. Price, DDS – Jay W. Hurley, DMD

Patient Name (s) _____

E-Mail _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Health History Update Information

Is this your child's first visit? **Yes** **No**

Are there any changes in the health of your child since the last visit? **Yes** **No**

List changes in your child's health since the last visit below:

Tree Nut Allergy

Does your child have a tree nut allergy? **Yes** **No**

Does your child have a latex allergy? **Yes** **No**

Fluoride Consent

The American Academy of Pediatric Dentistry recommends a professional topical fluoride application for children with a moderate risk of cavities be done at least every six months. This helps to prevent cavities. Some insurance companies, in an effort to reduce their costs, only cover the procedure once a year. We believe it is still an important part of your child's routine dental visit. Please indicate your choice concerning the procedure.

_____ I would like my child to have a topical fluoride application every six months, whether the insurance company covers the procedure or not. The cost is **\$39.00** payable at time of service.

_____ I would like my child to have a topical fluoride application **ONLY** if the insurance company covers the procedure.

Insurance Information

Are there any changes in insurance coverage since the last visit? **Yes** **No**

List any Changes _____

Treatment Consent

I authorize the staff to perform any necessary services needed during diagnosis and treatment, including but not limited to: exam, prophylaxis, x-rays, sealants, and composite resins. I understand the above information and certify this form was completed to the best of my knowledge.

On occasion when a pediatric dentist is not available for the examination or needed fillings these procedures may be completed by a general dentist – if you have any objection please inform the front desk and your child will be reappointed to the pediatric doctor's schedule.

Parent's Signature _____ Date _____