Pediatric Dental Clinic
David H. Merritt, D.M.D., M.S., P.C.
162 Ana drive
Florence, Alabama 35630
256-766-0270

Father: _____ DOB: _____ SS#: _____
Home Address: _____
City, State, Zip Code: _____
Home #: _____ Work #: _____ Cell #: _____
Employed By: _____
Address: _____
City, State, Zip Code: _____
Do you have dental insurance? Yes_____ No _____
If yes, Name of Company _____
Group #: _____ Policy #: _____
Family Dentist: _____
Email Address: _____

Mother: _____ DOB: _____ SS#: _____
Home Address: _____
City, State, Zip Code: _____
Home #: _____ Work #: _____ Cell #: _____
Employed By: _____
Address: _____
City, State, Zip Code: _____
Do you have dental insurance? Yes_____ No _____
If yes, Name of Company _____
Group #: _____ Policy #: _____
Family Dentist: _____
Email Address: _____

Child's Name: _____ Nickname: _____
Age: _____ DOB: _____ Race: African American _____
Male: _____ Female: _____ Caucasian _____
Social Security #: _____ Hispanic _____
Other _____

Attends what school? _____
Names and ages of brothers and sisters _____
Child's physician or pediatrician _____
Whom may we thank for referring you? _____
Nearest relative not living in the same household _____
Address: _____ Phone #: _____

Be Sure to Like our Page on FACEBOOK! Pediatric Dental Clinic- Dr. David Merritt, DMD, MS

CHILD'S HEALTH HISTORY

Has your child experienced any of the following?

	Yes	no		yes	no		yes	no
Heart diseases	___	___	Liver problems	___	___	Seizure disorder	___	___
Heart murmur	___	___	Hepatitis	___	___	Speech disorder	___	___
Rheumatic fever	___	___	Kidney problems	___	___	Hearing problems	___	___
Bleeding problems	___	___	Muscle problems	___	___	Vision problems	___	___
Anemia	___	___	Premature birth	___	___	Cerebral palsy	___	___
Blood transfusions	___	___	Diabetes	___	___	Headaches	___	___
Asthma	___	___	Mental disorder	___	___	Mental retardation	___	___
Allergies	___	___	Nervous disorder	___	___	HIV positive	___	___
Bronchitis	___	___	Fainting	___	___	AIDS	___	___
			Autism	___	___			

Other health problems _____
Has any immediate family member had any of the above? _____
Is your child taking any medications? _____
Has your child ever been hospitalized? _____
Has your child ever had any surgery? _____
Has your child ever had an allergic reaction to any medication such as Penicillin or Novocain? _____
When did your child last have a physical exam? List date and physician. _____

CHILD'S DENTAL HISTORY

Is this your child's first visit to the dentist? _____
If no, please list the dentist previously seen, the date, and the services provided
_____
What is your main concern about your child's dental health? _____
Has your child ever complained about a dental problem, or had any unhappy dental experiences?
_____
Is your child presently having a dental problem? _____
Has your child had any injuries to the mouth or face area? _____
Was your child breast fed? _____
Was your child bottle fed? _____
Has your child ever worn orthodontic appliances? _____
What is your source of drinking water? (City, County, Well, spring, or other) _____
Has your child ever been given fluoride? (Such as vitamins, drops, or tablets) _____
How often are your child's teeth brushed? _____
Is your child assisted in brushing and flossing? _____
Do you consider your child to be: advanced in learning ___ progressing normally ___ slow learner ___
How do you expect your child to behave in our office? _____
Thank you for your help! If there is any more information that you feel might be of value to us in the treatment of your child please add it here: _____

PARENT OR GUARDIAN SIGNATURE: _____ DATE: _____

PEDIATRIC DENTAL CLINIC

DAVID H. MERRITT, D.M.D., M.S., P.C.
162 ANA DRIVE
FLORENCE, AL 35630
(256) 766-0270

PAYMENT POLICY

PATIENT NAME:_____

PERSON RESPONSIBLE FOR PAYMENT:_____

SS#_____RELATION TO PATIENT:_____

ADDRESS: _____

HOME#_____OFFICE#_____CELL#_____

- FOR OUR PATIENTS WITHOUT DENTAL INSURANCE:
  -PAYMENT IS DUE WHEN SERVICES ARE RENDERED
  -ALL MAJOR CREDIT CARDS ARE ACCEPTED

- FOR OUR PATIENTS WITH DENTAL INSURANCE:
  -CO-PAYMENT IS DUE WHEN SERVICES ARE RENDERED
  -WE WILL FILE AN INITIAL CLAIM FOR THE DENTAL PROCEDURE
  THE AMOUNT OF PAYMENT WILL BE HELD CURRENT FOR 60
  DAYS, IF AFTER 60 DAYS THE CLAIM HAS NOT BEEN PAID BY THE INSURANCE
  COMPANY, YOU WILL BE HELD RESPONSIBLE FOR PAYMENT IN FULL.

I HAVE READ THE ABOVE PAYMENT POLICY FOR THE PEDIATRIC DENTAL CLINIC AND AGREE TO SUBSCRIBE TO THE APPROPRIATE PAYMENT POLICY PROCEDURE. SHOULD I DEFAULT ON PAYMENT OF ANY MONIES OWED TO DR. DAVID H. MERRITT, I AGREE TO PAY ALL COSTS OF COLLECTIONS, COURT COSTS, FILING FEES, AND ATTORNEY FEES ASSOCIATED WITH RECOVERING THE AMOUNT OWED. I ASLO AGREE TO ANY THIRD PARTY CALLS NECESSARY TO COLLECT ON THIS ACCOUNT.

SIGNATURE OF RESPONSIBLE PARTY: _____

DATE: _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my child's protected health information. These rights are given to me under the Health Insurance Portability Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my child's protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my child's treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Private Practices, which contains a more complete description of the uses and disclosures of my child's protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my child's protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do not agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20____.

Print patient name: _____

Relationship to patient: _____

Signature: _____

David H. Merritt D.M.D., M.S., P.C.
162 Ana Drive
Florence, Alabama 35630
256-766-0270

David H. Merritt, D.M.D.
162 Ana Drive
Florence, Alabama 35630
256-766-0270
Fax: 256-766-8328

OFFICE POLICY

Our office requires a 24 hour notice if for any reason you are unable to keep your child's appointment. If you are more than 15 minutes late we will see your child on a work in basis. If you break two appointments in a row without giving us any notice, we will ask that you find another pediatric dentist.

You must notify us of changes in your telephone number. We attempt to confirm your child's dental appointment a day in advance. It is still your responsibility to keep your appointment if your telephone number is disconnected or not in service and we were unable to contact you to confirm the appointment.

We want your child to have a pleasant experience at our office. We will be happy to answer any questions you may have before or after treatment.

Parent/ Guardian Signature: _____

Date: _____

Pediatric Dental Clinic

David H. Merritt, Jr., D.M.D., M.S.
Pediatric Dentistry
162 Ana Drive
Florence, Alabama 35630

Telephone (256) 766-0270

I GIVE MY CONSENT TO USE A PICTURE OF MY CHILD, _____

ON THE PEDIATRIC DENTAL CLINIC FACEBOOK PAGE.

SIGNED_____ RELATIONSHIP_____

DATE_____