GEORGE M. SHORT, D.D.S.
BRIAN C. SHORT, D.D.S.

RECALL EXAMINATION

CHILD'S NAME | DATE OF BIRTH | HOME PHONE | WORK PHONE PARENT'S | CELL PHONE PARENT'S

MAILING ADDRESS | CITY | STATE | ZIP CODE

Is there any change in medical history? _____ If so explain: _____

Is the patient pregnant? _____YES _____ NO

Reason for child's visit: _____

If you are unable to bring your child for his or her appointment, who has permission to authorize dental treatment?

Name _____ Relationship _____

If your child has dental Insurance and Tenn Care, it is insurance fraud if you do not inform us of your insurance coverage. It must be filed first.

Does the patient have Tenn Care? _____ Cover Kids? _____

Does the patient have dental insurance through a parent or legal guardian's work? _____

Name of Insurance Company _____

Is your child part of a Headstart Program? _____

Insurance and Tenn Care only pay for one check-up every six months. If you have been to another dental office in the last 6 months, please let us know.

Parent or Guardian's Consent: I hereby give permission for my child to receive routine dental treatment, which the doctor deems necessary and appropriate. Routine treatment may include, but not be limited to, topical anesthetic, intermittent radiographs, local anesthetics (injections), nitrous oxide, etc.

HAS YOUR CHILD **EVER** BEEN DIAGNOSED WITH A **HEART MURMUR**? **YES OR NO**

DOES THE CHILD HAVE A MEDICAL CONDITION WHERE ANTIBIOTICS **MUST** BE TAKEN BEFORE **EVERY** DENTAL VISIT? **YES OR NO**

SHOULD YOU FORGET TO OBTAIN A SCHOOL EXCUSE WHILE HERE, DO YOU GIVE PERMISSION TO HAVE IT FAXED TO YOUR CHILD'S SCHOOL? **YES OR NO**

_____
SIGNATURE OF PERSON COMPLETING FORM

_____
RELATIONSHIP TO PATIENT

_____
DATE

-OVER-

BROKEN APPOINTMENT POLICY:

OUR OFFICE DOES NOT CHARGE FOR BROKEN APPOINTMENTS, BUT AFTER THREE, WE MAY NOT BE ABLE TO RESCHEDULE YOUR CHILD IN THIS OFFICE. THIS DOES NOT INCLUDE APPOINTMENTS CANCELLED PRIOR TO APPOINTMENT TIME.

THIS POLICY HELPS US TO SERVE YOU IN A MORE TIMELY MANNER AND IF WE KNOW IN ADVANCE YOU ARE UNABLE TO KEEP YOUR APPOINTMENT, WE ARE ABLE TO SCHEDULE OUR PATIENTS WHO HAVE TOOTHACHES OR OTHER DENTAL EMERGENCIES.

THANK YOU FOR YOUR COOPERATION IN THIS MATTER.

I HAVE READ THE ABOVE POLICY.

_____

SIGNATURE OF PARENT OR LEGAL GUARDIAN