pediatric dentistry, psc

Nancy Mussetter, DMD
Email: office@ashlandpediatricdentistry.com
Website: ashlandpediatricdentistry.com
2129 Argillite Rd
Flatwoods, Ky 41139
Ph: 606-329-1440 Fax: 606-329-2441

Child's Name: _____ Birthday: _____
Concerns: _____
Is your child adopted? □ Yes □ No Who has custody of child: _____
Child lives with: _____
Home phone: _____ Cell phone: _____
Home Address: _____ Home Phone: _____
City: _____ State: _____ Zip: _____
We have Therapy Dogs, Rosie (Golden Doodle) & Theo (Schnauzer), in our office. Please list any concerns you may have.

_____
Child's Pediatrician: _____ Immunization up to date?
List any medications your child is currently taking: _____
Is your child allergic to any medications? ____ If yes, please list: _____
Any new allergic reactions or allergies diagnosed since the child's last appointment? □ Yes □ No
If yes, please list: _____

Any hospitalization or surgery since the child's last appointment? □ Yes □ No
If yes, please list issue and date: _____
_____

Any new behavioral issues diagnosed since the child's last appointment? □ Yes □ No
If yes, please list: _____
_____

Any new medical issues diagnosed since the child's last appointment? □ Yes □ No
If yes, please list: _____
_____

Any changes in the child's dental insurance? □ Yes □ No
If yes, please list: _____
_____

Kentucky Law (KRS 313.040) allows a Licensed Dental Hygienist to evaluate patients without the doctor being present in the office if the doctor has examined the patient within the last 7 months. I consent for my child to be seen under General Supervision and to all covered preventative care including radiographs, pit and fissure sealants and fluoride. **INITIAL**: _____

Financial Agreement

I hereby authorize the provider to release any information including diagnosis and records to the third-party payer and/or health care practitioners. I authorize and request my insurance to pay directly to the above-named provider. I understand I am financially responsible for any charges not covered by my insurance or by this authorization. I realize that failure to keep this account current may result in the provider unable to provide additional services. Patients with insurance must provide accurate and complete insurance information. You will be required to pay your portion the day of the treatment.

SIGNATURE: _____ DATE: _____