



5306 South Blvd., Suite A  
 Charlotte, NC 28217  
 P: (980) 226 - 5400

### PATIENT INFORMATION

PATIENT'S NAME:		NICKNAME:	
DATE OF BIRTH:	AGE:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
HOME ADDRESS:		CITY, STATE, ZIP CODE:	
PHONE #	Alt. Phone #:		
NAME OF SCHOOL/DAYCARE:			
CHILD'S PHYSICIAN NAME:		PHYSICIAN'S PHONE #:	
DATE OF LAST EXAM:	CURRENT WEIGHT:	CURRENT HEIGHT:	

### PARENT/GUARDIAN INFORMATION

PARENT/GUARDIAN FULL NAME:		RELATIONSHIP TO PATIENT:	
SOCIAL SECURITY#:	DOB:	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female	
EMPLOYER	WORK PHONE #:		
EMAIL ADDRESS:	HOW DID YOU HEAR ABOUT OUR OFFICE?		

### WHO ELSE IS AUTHORIZED TO BRING YOUR CHILD?

Full Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Full Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

### DENTAL INSURANCE INFORMATION

**PART 1**

Do you have North Carolina Medicaid or NC Health Choice?  YES  NO (If you checked yes, please skip Part 2)

**PART 2 --- Private Insurance Only:**

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
INS. COMPANY NAME:	Ins. Company Name:
POLICY HOLDER NAME:	Policy Holder Name:
POLICY HOLDER DOB:	Policy Holder DOB:
POLICY HOLDER SS#:	Policy Holder SS#:
RELATIONSHIP TO PATIENT:	Relationship to Patient:



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## DENTAL HISTORY

Reason for visit today: \_\_\_\_\_ Date of Last Dental Exam: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ Former Dentist Phone #: \_\_\_\_\_

Do you have current records (including x-rays) from another office?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	
Has your child complained about any dental problems?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	If yes, describe:
Any injuries or surgeries to the mouth, teeth, or head?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	If yes, describe:
Does your child still take the bottle or sippy cup?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	
Does your child brush daily?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	How often:
Is dental floss used?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	How often:
Do you assist your child with brushing?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	
Does your child have any of the following habits?	<input type="checkbox"/> Thumb Sucking <input type="checkbox"/> Pacifier <input type="checkbox"/> Finger Sucking <input type="checkbox"/> Grinding <input type="checkbox"/> Nail Biting <input type="checkbox"/> N/A	
How does your child receive fluoride?	<input type="checkbox"/> Water Supply <input type="checkbox"/> Dentist <input type="checkbox"/> Toothpaste <input type="checkbox"/> Tablets <input type="checkbox"/> Other	
Child's attitude towards dentistry:	<input type="checkbox"/> Outstanding <input type="checkbox"/> Good <input type="checkbox"/> Adequate <input type="checkbox"/> Other	

## MEDICAL HISTORY

Allergies (Food, Drug, Dust, Additional) If Yes, please list:	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Is your child currently taking any medications? If yes, please list down below	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Rheumatic Fever/Rheumatic Heart Disease If Yes, is Pre-Med Needed? <input type="checkbox"/> Yes   <input type="checkbox"/> No	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Are your child's immunization's current?	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Diabetes TYPE 1 or TYPE 2 (circle one)	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Speech, Learning, or Hearing Disorders	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Convulsions, Seizures, Fainting, or Epilepsy	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Asthma or Hay Fever	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Bleeding Disorder	<input type="checkbox"/> Yes   <input type="checkbox"/> No
High or Low Blood Pressure (circle one)	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Kidney or Bladder Problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Tuberculosis or other lung problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Liver Problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Heart Murmur, Mitral Valve Prolapse, Heart Defect	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Hepatitis, jaundice or other liver disease	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Psychological or Emotional Problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No
AIDS or HIV positive	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Cancer/Tumor	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Explain any other Medical Concerns: _____			
Medications/Supplements: _____			

I have read and answered the above questions to the best of my knowledge.

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_



**ANESTHESIA CONSENT**

**Local Anesthesia (Tickle Juice)**

I understand that local anesthesia may be used during the dental treatment. I understand that there are risks involved with anesthesia. These risks include but are not limited too; dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, and allergic reaction. I am aware that local anesthesia may take a while to subside so I must be aware that my child doesn't bite him/herself.

**Nitrous Oxide (Laughing Gas)**

I understand that nitrous oxide and oxygen may be used during dental treatment. Nitrous oxide is perhaps the safest sedative in dentistry. It also carries risks. These risks include but are not limited too; dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, and allergic reaction. Please ask the staff if you have any questions or concerns regarding this consent form.

**I hereby acknowledge that I have read this consent regarding anesthesia.**

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**AUTHORIZATION AND CONSENT**

I hereby authorize the performance of dental services upon the above-named patient and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorized and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

**Kidz Dental South** is authorized to release protected health information about the patient to the entities listed below. The purpose is to inform the patient or others in keeping up with the patient's dental health.

Release of information is allowed to the parties below: **(check all that apply)**

**Voicemail**             Yes |  No

**Spouse**             Yes |  No      **Spouse Name:** \_\_\_\_\_

**Other Family Member(s)**     Yes |  No      **Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**The patient/responsible party has the right to revoke this authorization at any time with written notice to the provider.**

Parent/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**TERMS AND CONDITIONS**

I hereby certify that all of the above information is correct and true. I agree to be responsible for all charges for dental services and materials not paid by my dental plan, unless **Kidz Dental South** has a contractual agreement with my plan prohibiting all or a portion of such charges. I authorize **Kidz Dental South** to release any medical information to my insurance carrier or third-party payer to facilitate processing my insurance claims. I authorize payment of the dental benefits otherwise payable to me to be paid directly to **Kidz Dental South**.

I hereby certify that all of the above information is correct and true. If the above-named patient is a minor, it is necessary that a signed permission form is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Furthermore, I authorized **Kidz Dental South** to provide dental treatment for my child.

**There may be a charge of \$30 for any missed appointments or appointments not cancelled 24 hours before the appointment time.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_



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**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I, \_\_\_\_\_ have received a copy of this office's Notice of Privacy Practices.

\_\_\_\_\_  
(Please Print Name of Patient)

\_\_\_\_\_  
(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
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_