2620 Central Avenue
Charlotte, NC 28205
P: (980) 875-9158

PATIENT INFORMATION

PATIENT'S NAME:	NICKNAME:	
DATE OF BIRTH:	AGE:	SEX: ☐ Male ☐ 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: ☐ Male ☐ Female
EMPLOYER	WORK PHONE #:	
EMAIL ADDRESS:	HOW DID YOU HEAR ABOUT OUR OFFICE?	

EMERGENCY CONTACT

Full Name: ______________________________________ **Phone #:**____________________________ **Relationship:** ___________________

DENTAL INSURANCE INFORMATION

PART 1

Do you have North Carolina Medicaid or NC Health Choice? ☐ YES ☐ NO **(If 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 any current records (including x-rays) from another office?	☐ **Yes** | ☐ **No**	
Has your child complained about any dental problems?	☐ **Yes** | ☐ **No**	**If yes, describe:**
Any injuries or surgeries to the mouth, teeth, or head?	☐ **Yes** | ☐ **No**	**If yes, describe:**
Does your child still take the bottle or sippy cup?	☐ **Yes** | ☐ **No**	
Does your child brush daily?	☐ **Yes** | ☐ **No**	**How often:**
Is dental floss used?	☐ **Yes** | ☐ **No**	**How often:**
Do you assist your child with brushing?	☐ **Yes** | ☐ **No**	
does your child have any of the following habits?	☐ **Thumb Sucking** ☐**Pacifier**	☐ **Finger Sucking** ☐ **Grinding** ☐ **Nail Biting**
How does your child receive fluoride?	☐ **Water Supply** ☐**Dentist**	☐ **Toothpaste** ☐ **Tablets** ☐**Other:**
Child's attitude towards dentistry:	☐ **Outstanding** ☐ **Good**	☐ **Adequate** ☐ **Other:**

MEDICAL HISTORY

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

Explain any other Medical Concerns: ____

Is your child currently taking any medications? ☐ **Yes** | ☐ **No** **If yes, please list:** ______________________

Physician's Name: ____________________ **Physician's Phone #:** ____________**Date of last visit:** __________

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

Parent/Guardian Name: ____________________ **Signature:** ____________________ **Date:** ____________

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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.

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 Central** 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) (Example: Stepfather, Stepmother, Aunt.. Etc) ☐ Yes | ☐ No Name: ____

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:** ___________________

PATIENT'S RIGHTS

- I have the right to revoke this authorization at any time in person or in writing.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization mat be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV or a diagnosis related to mental health or substance abuse.
  THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL REVOKED BY THE PATIENT IN WRITING.

Signature of patient or Personal Representative: __________________________________ **Date:**_______________________

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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 Central** has a contractual agreement with my plan prohibiting all or a portion of such charges. I authorize **Kidz Dental Central** 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 Central**.

☐ 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 Central** 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:** ____________________________

COVID-19 PANDEMIC AND NEW OFFICE PROTOCOL

I___________________________________, Knowingly and willingly consent to have Hygiene, dental treatment completed during the COVID-19 pandemic for child's___________________________________.

I understand the COVID-19 virus has a long incubation period during which carriers of the virus may not show symptoms and still be highly contagious. It is impossible to determine who has it and who does not, given the current limits in virus testing.

Dental Procedures create water spray which is how the disease is spread. The ultra-fine nature of the spray can linger in the air for minutes to sometimes hours, which can transmit the COVID-19 virus.

I understand that due to frequency of visits of other dental patients, the characteristics of the virus, and the characteristics of dental procedures, that I have an elevated risk of contracting the virus simply by being in a dental office ________ (INITIALS)

I confirm that I am not presenting any of the following symptoms of COVID-19 listed below:

- Fever
- Shortness of breath
- Dry cough
- Running nose
- Sore throat

________ (INITIALS)

We ask all parents to wash their hands and always wear a mask during their appointment time, our waiting area is closed, we have few chairs, and we ask them not to be moved, all children under 18 years of age need to be with their legal guardian/parent. They are required to always wear masks. Body temperature of every patient is recorded when they arrive for their appointment.

Office is disinfected in accordance with ADA guidelines on a regular schedule throughout the day.

I understand the new office protocol and will follow and respect their new guidelines. If I fail to do so, they have right to dismiss and cancel all our future appointments.

Signatures: ______________________________ **Date: ______________________________**