Taylorsville Pediatric Dentistry

167 1st Ave SW
Taylorsville, NC 28681
P: (828) 317-3293

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?**	

WHO ELSE IS AUTHORIZE 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:**

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POLICY HOLDER NAME:	**Policy Holder Name:**
POLICY HOLDER DOB:	**Policy Holder DOB:**
POLICY HOLDER SS#:	**Policy Holder SS#:**
RELATIONSHIP TO PATIENT:	**Relationship to Patient:**

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?	**☐ 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 ☐ N/A**	
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 down below**	☐ 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

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AIDS or HIV positive	☐ Yes | ☐ No	**Cancer/Tumor**	☐ Yes | ☐ 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:** _____

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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 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. Also, if you are more than 15 minutes late you may be asked to reschedule.

☒Any new patients not show up for their first appointment we will not reschedule.

Signature: _____ Date: _____ Relationship to Patient: _____