New Patient Medical and Dental History For Children

Child's Name_____ **Date of Birth**_____

Address_____

Home phone _____ **EmergencyContact Name**_____ **Phone number** _____

Name and phone number of child's primary care physician_____

Is your child under the care of any specialist physician? **[ ] Yes [ ] No**

If yes, please state name and specialty_____

Are all immunizations current? **[ ] Yes [ ] No**

Is your child allergic to anything? (Medication, Latex, Foods) **[ ] Yes [ ] No**

If yes, what? _____

Is your child talking any medication at this time? **[ ] Yes [ ] No**

If yes, what?_____

Has your child ever been hospitalized? **[ ] Yes [ ] No**

If yes, for what?_____

Has your child ever had surgery or general anesthesia? **[ ] Yes [ ] No**

If yes, what for and were there any complications?_____

Has your child ever been diagnosed as having any of the following conditions:

YES /NO ADD/ADHD	**YES/NOCongenital Birth Defects**	**YES/NO Nutritional Deficiency**
YES/NOAnemia	**YES/NO Diabetes**	**YES/NO Orthopedic Problems**
YES/NOArthritis	**YES/NO Emotional Disturbances**	**YES/NO Premature Birth**
YES/NOAsthma	**YES/NOEye Problems**	**YES/NO Pregnancy**
YES/NO Autism	**YES/NO Fainting**	**YES/NO Respiratory Syncytial Virus(RSV)**
YES/NO Brain Injury	**YES/NO Handicaps/Disabilities**	**YES/NO Seizure Disorder**
YES/NO Behavioral Problems	**YES/NO Hearing Impairment**	**YES/NOSickle Cell Anemia/Trait**
YES/NO Bleeding Problems	**YES/NO Heart condition/Heart murmur**	**YES/NO Speech Problems**
YES/NO Breathing Problems	**YES/NO Hemophilia**	**YES/NOSpina Bifida**
YES/NO Cancer/ Leukemia	**YES/NO Hepatitis**	**YES/NO Syndrome** _____
YES/NO Cerebral Palsy	**YES/NO Kidney/Liver Problems**	**YES/NO Tetanus**
YES/NO Cleft Lip/Palate	**YES/NO Learning Disability**	**YES/NO Other** _____

Is this your Child's first visit to the dentist? [ ] Yes [ ] No

If not, how long since the last visit to the dentist? _____ . Were x-rays taken? [ ] Yes [ ] No

Previous dentist's name:

_____

Has your child ever had any injuries to their teeth, mouth or face? [ ] Yes [ ] No

If yes, please explain.

_____

Does your child have any of the following habits?

Thumb/finger sucking [ ] Yes [ ] No Pacifier [ ] Yes [ ] No Nail biting [ ] Yes [ ] No

Does your child currently nurse or take a bottle? [ ] Yes [ ] No

How often are your child's teeth brushed? _____

How often are they flossed? _____

Is your child's water fluoridated? [ ] Yes [ ] No Is the child receiving fluoride supplements? [ ] Yes [ ] No

Has your child ever had a serious or difficult problem associated with previous dental work? [ ] Yes [ ] No

If yes, please explain.

_____

What is your reason for bringing your child to the dentist today?

_____

How do you think your child will react today? (e.g.: shy, anxious, cooperative, defiant)

_____

Is there anything else you think we should know about your child?

_____

How did you hear about our office? _____

Name: _____ Signature: _____

Today's Date _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Telephone: 704-847-7426 Fax: 704-847-5417

Address: 2435 Plantation Center Drive, Suite #100 Matthews, NC 28105

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

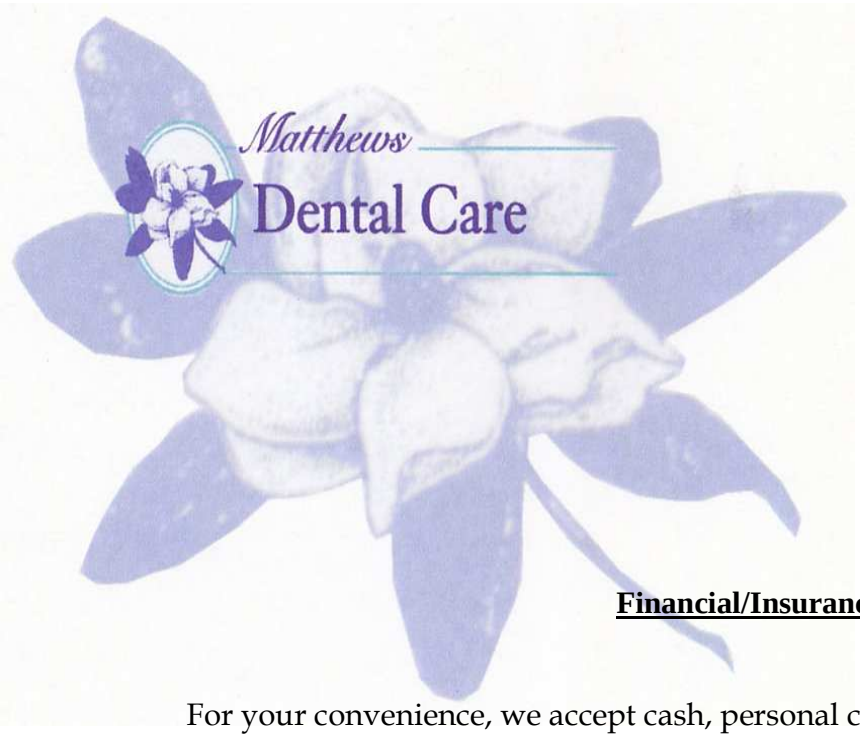
If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.



Financial/Insurance Policy

For your convenience, we accept cash, personal checks, money orders and major credit cards. Payment is expected at the time services are performed.

We do not file secondary claims, however we will give you any information along with filing instructions for your convenience.

Insurance

As a service to our patients, our practice accepts most dental insurance programs, including non-managed care, indemnity (traditional) and PPO out-of-network. **We are not part of any managed care network.** Our accounting staff will prepare all the necessary forms for your dental benefits. However, we remind you that your specific policy is an agreement between you and your insurance company. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage that anticipated.

We want to make your visit with us as pleasant and convenient as possible. If you have any questions or concerns, please feel free to speak to our treatment coordinator.

Signature

V. Paul Palermo, DDS, PA
Warren D. Surface, DDS, PA
Brian S. Clarke, DDS, PA
T. Bradley Callahan, DDS
2435 Plantation Center Drive, Suite 100
Matthews, NC 28105
704-847-7426 704-847-5417 (Fax)
e-mail: appointments@matthewsdentalcare.com
www.MatthewsDentalCare.com

Matthews Dental Care

Dental Insurance Information

Policy Holder's Name:

Date of Birth:

Policy Holders SSN or Member ID:

Policy Holder's Employer:

Insurance Company:

Group #:

Insurance Co. Phone Number:

Do you know when your insurance plan ends and/or plan year terminates?

How did you hear about our office?