Welcome to Pediatric Dentistry & Orthodontics office of

Charles W. Connor Jr., DDS, MS

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

CHILD'S Last Name ______ First ______ Middle ______ Child's SSN ______ Today's Date ______

Birthdate ______ Age ______ Sex ______ Race ______ School ______

Child's Home Address ______ Zip Code ______

Lives with Both Parents / Mother / Father / Other ______

Brothers ______ Sisters ______ Pets ______

Child's Physician ______ Last Seen ______ Pharmacy ______ Telephone ______

Guardian Information (who child lives with)

Mother Stepmother Guardian

Name ______ Middle Initial ______ Marital Status: Single, Married, Divorced, Widowed, Separated

Address (if different from above) ______

Home Phone ______ Work Phone ______ Cell Phone ______

Employer ______ Occupation ______ Email Address ______

Driver's License # ______ SS # ______ Mother's DOB ______

Father Stepfather Guardian

Name ______ Middle Initial ______ Marital Status: Single, Married, Divorced, Widowed, Separated

Address (if different from above) ______

Home Phone ______ Work Phone ______ Cell Phone ______

Employer ______ Occupation ______ Email Address ______

Driver's License # ______ DOB ______ SS # ______

Dental Insurance Information (Primary Only)

Insured's Name ______

Relationship ______

Birthdate ______ Soc Sec # ______

Employer ______

Ins Company ______

Ins Co Address ______

ID# ______ Group# ______

Has your child received previous dental care under this plan? Y N

Reason for bringing child to dentist ______

Whom may we thank for referring you ______

PLEASE HAVE MOST RECENT DENTAL INSURANCE CARD

MEDICAL HISTORY

PATIENT'S NAME ____________________

PHYSICIAN'S NAME ____________________ DATE OF LAST PHYSICAL EXAM ____________

CHILD'S AGE ____________

Please be specific by checking (✓) the box that applies to your child. Blank lines are available to use as needed for explanations.

- ☐ Allergic to latex (rubber) ____________
- ☐ Allergic to any foods ____________
- ☐ Allergic to Codeine ____________
- ☐ Allergic to local anesthetics ____________
- ☐ Allergic to Penicillin ____________
- ☐ Allergic to any other Antibiotics? ____________
- ☐ Allergic to Barbituates, sedatives, or sleeping pills ____________
- ☐ Allergic to Asprin ____________
- ☐ Allergic to Iodine ____________
- ☐ Other? ____________
- ☐ Heart murmur ____________
- ☐ Heart problems ____________
- ☐ Mitral valve prolapse ____________
- ☐ Heart disease ____________
- ☐ Radiation treatment ____________
- ☐ Excessive bleeding ____________
- ☐ Anemia or blood problems ____________
- ☐ Asthma ____________
- ☐ Seasonal Allergies ____________
- ☐ Diabetes ____________
- ☐ Kidney problems ____________
- ☐ Liver problems or Hepatitis ____________
- ☐ Cancer ____________
- ☐ Psychiatric (mental) problems ____________
- ☐ Emotional problems ____________
- ☐ Physical handicaps ____________
- ☐ Mental handicaps ____________
- ☐ Congenital birth defects ____________
- ☐ ADHA ____________
- ☐ ADD ____________
- ☐ Rheumatic Fever ____________
- ☐ Scarlet Fever ____________
- ☐ Skin Rash ____________
- ☐ Immune System Disorders (AIDS, HIV, ARC) ____________
- ☐ Sinus problems ____________
- ☐ Thyroid disorders ____________
- ☐ Eye disorders ____________
- ☐ Contact lenses ____________
- ☐ Tonsil or Adenoid problems ____________
- ☐ Speech disorders ____________
- ☐ Hearing problems ____________
- ☐ Endocrine problems ____________
- ☐ Ulcer or Colitis ____________
- ☐ Seizures ____________
- ☐ Epilepsy ____________
- ☐ Lung or breathing problems ____________
- ☐ Tuberculosis ____________
- ☐ Extreme nervousness ____________
- ☐ Ever taken Fen-Phen/Redux ____________

Please list any medications (including dosages and frequency) your child takes ____________

Please list any drugs that have adverse reactions in your child. ____________

List any other information that you feel might be of value to us in treating your child. ____________

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or child's) health. It is my responsibility to inform the dental office of any changes in medical status.

DENTAL HISTORY

Please be specific by checking (✓) the box that applies to your child. Blank lines are available to use as needed for explanations.

CHIEF COMPLAINT ____________

PREVIOUS DENTIST ____________ PHONE # ____________ DATE OF LAST DENTAL EXAM ____________

ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE ☐ YES ☐ NO EXPLAIN ____________

- ☐ Tooth Pain ____________
- ☐ Traumatic injury to mouth or teeth ____________
- ☐ Teeth sensitivity ____________
- ☐ Bleeding gums ____________
- ☐ Food impaction ____________
- ☐ Clenching or grinding ____________
- ☐ Swelling or lumps in mouth ____________
- ☐ Frequent fever blisters or cold sores ____________
- ☐ Pain around ear ____________
- ☐ Bad breath ____________
- ☐ Complications from extractions ____________
- ☐ Orthodontic treatment ____________
- ☐ Mouth breathing ____________
- ☐ Oral habits, thumbsucking, fingernail biting,
- ☐ cheek biting, etc. ____________
- ☐ Frequency of brushing ____________
- ☐ Frequency of dental flossing ____________
- ☐ Fluoride supplements ____________
- ☐ Topical Fluoride Treatment ____________
- ☐ Between meal snacks ____________
- ☐ Well Balanced Diet ____________

Is there any other information about your child's teeth or smile that might be of value to us? ____________

____________________ SIGNATURE OF PATIENT. PARENT. or GUARDIAN

DATE ____________

Please tell us how you heard about our office

Phonebooks:_______________

Yellow Pages.Com________________

Newspaper:_________________

Office Sign:_________________

Website:____________________

Daycare/School Program:_________________

Employee Referral:___________________

Family Referral:__________________

Friend Referral:__________________

Pediatrician Referral: Dr.______________________City___________

Dentist Referral: Dr.__________________________City____________

Insurance Company (name of insurance):_________________________

Flyers:_____________________________

*Note: This Document Contain[illegible] Different Authorizations. Please Read Ca[illegible]lly, Sign and Date Each.

Notice of Privacy Practices Acknowledgement

Pediatric Dentistry and Orthodontics
1146 North New Hope Road
Gastonia, NC 28054

Acknowledgement of Hippa Policy

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that his organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

Patient Name: ______________________________
Relationship to Patient: ______________________________
Signature: ______________________________
Date: ______________________________

Consent to Release Pictures of Child/Children for Marketing or Educational Purposes.

I consent to allow my child/children's pictures to be displayed on our website. The pictures also may be displayed in our office as part of advertising services. We may use photos of our patients in our local newspaper or for training and teaching purposes.

Parent or Guardian: ______________________________
Date: ______________________________
______________________ Refusal of consent for these purposes listed above.

Authorization to Release Health Information or Consent for Treatment

Appointment of Personal Representative ie. grandparent, aunt, sibling, stepparent. *This person can bring child in for appointments.

1) ______________________ ______________________ ______________
Name Relationship Date

2) ______________________ ______________________ ______________
Name Relationship Date

3) ______________________ ______________________ ______________
Name Relationship Date

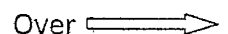
Signed______________________________ ______________
Signature of Parent Date

Authorization for Emails or Phone Calls

____________ Emails ____________ Phone Calls ____________ Voicemail

______________________ Leave Message with Next of Kin

______________________________ ______________
Signature of Parent Date

Over 

Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

_____ An emergency existed & a signature was not possible at the time.

_____ The Individual refused to sign.

_____ A copy was mailed with a request for a signature by return mail.

_____ Unable to communicate with the patient for the following reason:
____

_____ Other: ____
____

Date: ________________________________

Employee Name: ________________________

Reason: ____

____