Welcome to Premier Dental Associates of the Carolinas

NEW PATIENT PACKET (CHILD)

PLEASE FILL OUT THE FORM COMPLETELY AND IN INK.

PATIENT INFORMATION

Last Name_________________________ First Name______________________ Middle Name___________________

Birthdate_____/_____/________ Age______ Sex______ Social Security #________-_____-_________

Street Address____ Apartment/Unit# (if Applicable)____________

City__________ State____ Zip Code__________ Lives with Both Parents/Mother/Father/Other_______________

School (Full Name)__________________________________ School Address_________________________________

Any Brothers or Sisters? **O** Yes **O** No Are they also patients of Premier Dental Associates? **O** Yes **O** No

Phone Number (______)_______-___________ Email Address____

GUARDIAN INFORMATION

PARENT STEPPARENT GUARDIAN

Name_____________________________________ Middle Initial___ Single/Married/Separated/Divorced/Widowed

Sex____ Address (if different from above)____

Employer_________________________ Occupation____________________ Email______________________________

Home # (______)_______-_______ Work # (______)_______-_________ Cell # (______)_______-___________

Driver's License #______________________ SS#________-_____-_________ Birthdate_____/_____/________

PARENT STEPPARENT GUARDIAN

Name_____________________________________ Middle Initial___ Single/Married/Separated/Divorced/Widowed

Sex____ Address (if different from above)____

Employer_________________________ Occupation____________________ Email______________________________

Home # (______)_______-_______ Work # (______)_______-_________ Cell # (______)_______-___________

Driver's License #______________________ SS#________-_____-_________ Birthdate_____/_____/________

Patient Guardian (sign)____ Date _____/_____/________

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PLEASE FILL OUT THE FORM COMPLETELY AND IN INK.

Please make sure this information is your DENTAL INSURANCE and not your MEDICAL INSURNACE

INSURANCE INFORMATION (PRIMARY ONLY)

Patient's Name_______________________________ Insured's Name____________________________________

Relationship to Patient________________ DOB_____/_____/______ Social Security #________-_____-________

Employer_________________________________ Insurance Company___________________________________

Insurance Co. Address (either Full Address or P.O. Box info.)____

____

Claims Phone #: __(______)_______-__________

ID #___________________________ Group #__________________ Effective Coverage Date_____/_____/_____

Have you received previous dental care under this plan? **O** Yes **O** No

GENERAL CONSENT FOR TREATMENT AND FINANCIAL POLICES

I, ____, give permission to Dr. Bill Connor, Dr. Jack Brinkley and their auxiliary staff to administer treatment as needed to ____ by providing preventative basic and major dental services. These services include dental exam and x-rays that may be performed on my first visit and any subsequent visits.

PATIENTS WITH INSURANCE: I further acknowledge that I am currently a covered member/dependent under a Dental Insurance plan with __________________________________. We will file insurance benefits on your behalf to assist you in maximizing your dental coverage. If, for any reason, the above insurance company refuses to pay this claim (or subsequent claims), I agree that I am completely financially responsible for any and all charges associated with my account.

PATIENTS WITHOUT INSURANCE: I understand that Dr. Connor requires payment in full at the time services are rendered. We offer several affordable payment options.

Estimated down payment is expected at the time of operative appointment. Customized payment plan options include cash, credit card, in-house draft plans with no interest, and third-party financing with Lending Club and Wells Fargo.

I certify that I have read and understand the above information.

Patient Guardian (sign)___________________________________ Date _____/_____/________

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PLEASE FILL OUT THE FORM <u>COMPLETELY AND IN INK.</u> Patient's Name______________________ Patient's Age___

Please be specific by checking (✓) the circle that applies to your child. Explanations can be written in the lines provided.

MEDICAL HISTORY

O Allergic to Latex (Rubber)______________________________
O Allergic to Any Foods__________________________________
O Allergic to Codeine____________________________________
O Allergic to Local Anesthetics___________________________
O Allergic to Penicillin___________________________________
O Allergic to any other Antibodies_________________________
O Allergic to Barbiturates, Sedatives, or sleeping pills?________
O Allergic to Aspirin_____________________________________
O Allergic to Iodine______________________________________
O Other Allergies?_______________________________________
O Heart Murmur____
O Heart Problems____
O Mitral Valve Prolapse___________________________________
O Heart Disease____
O Radiation Treatment____________________________________
O Excessive Bleeding_____________________________________
O Anemia or Blood Problems_______________________________
O Asthma____
O Seasonal Allergies______________________________________
O Diabetes____
O Kidney Problems_______________________________________
O Liver Problems or Hepatitis______________________________
O Cancer____
O Psychiatric (Mental) Problems___________________________
O Emotional Problems_____________________________________

O Physical Handicaps_____________________________________
O Mental Handicaps_______________________________________
O Congenital Birth Defects_________________________________
O ADHD____
O ADD____
O Rheumatic Fever_______________________________________
O Scarlet Fever____
O Skin Rash____
O Immune System Disorders (AIDS,HIV,ARC)________________
O Sinus Problems____
O Thyroid Disorders_______________________________________
O Eye Disorders____
O Contact Lenses____
O Tonsil or Adenoid Problems______________________________
O Speech Disorders_______________________________________
O Hearing Problems_______________________________________
O Endocrine Problems_____________________________________
O Ulcer or Colitis____
O Seizures____
O Epilepsy____
O Lung or Breathing Problems______________________________
O Tuberculosis____
O Extreme Nervousness____________________________________
O Ever taken Fen-Phen/Redux_______________________________

Physician's Name____ Date of Last Physical Exam______/______/__________

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

____

Please list any drugs that have adverse reactions in your child____

DENTAL HISTORY

O Tooth Pain____
O Traumatic Injury to Mouth or Teeth______________________
O Teeth Sensitivity ______________________________________
O Bleeding Gums____
O Food Impaction____
O Clenching or Grinding___________________________________
O Swelling or Lumps in the Mouth__________________________
O Frequent Fever Blisters or Cold Sores_____________________
O Pain Around Ear____
O Bad Breath____
O Complications from Extractions__________________________

O Orthodontic Treatment__________________________________
O Mouth Breathing_______________________________________
O Oral Habits (Thumb Sucking, Fingernail Bighting, Cheek Biting, etc.)____
O Frequency of Brushing___________________________________
O Frequency of Dental Flossing______________________________
O Fluoride Supplements___________________________________
O Topical Fluoride Treatment_______________________________
O Between Meal Snacks____________________________________
O Well Balanced Diet______________________________________

Chief Complaint________________________________ Previous Dentist_____________________________ Phone# (______)_______-________

Date of Last Dental Exam_____/_____/________ Any Previous Unfavorable Dental Experience **O** Yes **O** No

If Yes, Explain____

List any other information that will 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 child's health. It is my responsibility to inform the dental office of any changes in medical status.

Patient Guardian (sign)____ Date _____/_____/________

Welcome to Premier Dental Associates of the Carolinas

PLEASE FILL OUT THE FORM COMPLETELY AND IN INK. Patient's Name______________________

Please answer YES or NO to the following questions.

SLEEP APNEA EVALUATION

1. Does your child have trouble going to/falling asleep?
2. Does your child awaken during the night and have trouble returning to sleep?
3. Does your child tend to breathe through their mouth during the day or during sleep?
4. Does your child have dry mouth or bad breath upon waking up?
5. Have you noticed any of the following while your child is sleeping:
   a) Snoring, heavy or loud breathing?
   b) Break or pause in breathing?
   c) Gasp, choke, or struggle to breathe?
   d) Restless or agitated sleep?
   e) Abnormal head posture (hyper-extension, etc.)?
   f) Excessive sweating?
   g) Wetting the bed?
6. Have you noticed any of the following during the day:
   a) Difficulty walking?
   b) Wakes with headaches?
   c) Groggy, tired or "out of it"?
   d) Hyperactive?
   e) Teachers commented?
7. Child often:
   a) Does not seem to listen when spoken to directly?
   b) Has difficulty organizing tasks?
   c) Easily distracted by extraneous stimuli?
   d) Fidgety with hands or feet or squirms in seat?
   e) Interrupts or intrudes on others?
8. Is your child frequently sick, have a history of sore throat, ear infections, sinus infections, or allergies?
9. Stop growing at a normal rate at any time since birth?
10. Habits such as pacifier/thumb sucking/lip biting/etc.

Patient Guardian (sign)____ Date _____/_____/________

Welcome to Premier Dental Associates of the Carolinas

(PREMIER DENTAL ASSOCIATES OF THE CAROLINAS)

Acknowledgement of Receipt
Of Notice of Privacy Practices

Patient Name & Address: ____
____
____

I have received a copy of the Notice of Privacy Practices for the above named practice.

________________________________ ______________________
Signature Date

For 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:____
  ____

Prepared By ______________________________________

Signature ______________________________________

Date ______________________________________

Welcome to Premier Dental Associates of the Carolinas

Authorization for Release of Information – Compound Release

Name of Patient: ________________________________ Date of Birth: _____________

____ is authorized to release PHI about the above named patient in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.
☐ Voice Mail	☐ Results of lab tests/x-rays ☐ Other______________________________
☐ Other person (s) (provide name and phone number)	☐ Financial ☐ Medical
☐ Email communication-Provide email address* ___________________________________ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Medical ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * ___________________________________ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: ___________________________________
☐ For **email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ Other: _____________________________________	☐ May be posted in office ☐ May be posted on website ☐ Other:__________________________________

Patient's Rights:

- I have the right to revoke this authorization at any time by contacting this office.
- 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 may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Personal Representative: ____ Date: __________

*Description of Personal Representative's Authority (attach necessary documentation)

☐ Revoked by patient or personal representative on ___________________________.
DATE

How revoked: ☐ orally (in person or via phone) ☐ in writing (place copy in patient's file)

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PLEASE FILL OUT THE FORM <u>COMPLETELY AND IN INK.</u> Patient's Name______________________

Please tell us how you heard about our office. Check (✓) the options that apply and write the name of the person who referred you if applicable.

REFERRAL FORM

O Office Sign

O Website

O Instagram

O Facebook

O Daycare/School

O Online Yellow Pages

O Employee________________________________

O Pediatrician Referral: Dr.___________________ City____________________

O Dentist Referral: Dr.___________________ City____________________

O Insurance Company: Name of Insurance_______________________________

O Friend Referral (Please share their name, address, and phone # so we may send a thank you card)

____

O Family Referral (Please share their name, your relationship, address, and phone # so we may send a thank you card)

____

Patient (sign)____ Date _____/_____/________