Eastfield Pediatric Dentistry and Orthodontics
8631 Arbor Creek Dr Suite D-3
Charlotte NC 28269

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

Patient name ______________________________ **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:**
Eastfield Pediatric Dentistry and Orthodontics will charge a fee of $50 for SAME DAY CANCELLATION or NO SHOW		**Please ask front desk if you have any question about our appointment policy**
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 have any flu like symptoms or fever?	☐ yes ☐ no	

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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FINANCIAL ARRANGEMENTS AND OPTIONS

Payment for treatment are collected on the same day. We offer several options to make the treatment we deliver acceptable.

1- We accept cash and credit cards ONLY
2- We accept the following credit cards: Visa, MasterCard, Discover, and American Express
3- If you require an extended payment plan, we offer qualifying parents the Care Credit Program.
Please ask a staff member for details.
4- There is a $50.00 charge for failed appointments that are scheduled and confirmed.
5- There will be a $50.00 charge for accounts that go into collections. Accounts that are in collections will not be considered for treatment until paid in full.
7- As a courtesy, we will gladly file your dental insurance and accept assignment of payment provided, please understand you are responsible for any charges not paid by your insurance.
8-You must provide an insurance card with all the necessary information for us to verify coverage and file your claim day before the appointment.

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 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.

☑ **Eastfield Pediatric Dentistry and orthodontics** 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 can the parties below: (**check all that apply)**

Voicemail ☐ Yes | ☐ No

Spouse ☐ Yes | ☐ No Spouse Name: ____

Other Family Member(s) ☐ 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: __________________

TERMS AND CONDITIONS

☑ I hereby certify that all 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 **Eastfield Pediatric Dentistry and Orthodontics** has a contractual agreement with my plan prohibiting all or a portion of such charges. I authorize **Eastfield Pediatric Dentistry and Orthodontics** 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 **Eastfield Pediatric Dentistry**

☑ I hereby certify that all 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 t Eastfield Pediatric Dentistry and Orthodontics to provide dental treatment for my child.

☑ **There may be a charge of $50 for any missed appointments or appointments not cancelled 24 hours before the appointment time.**

Signature: ____ Date: _________________ Relationship to Patient: ___________________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ____ have read a copy of this office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: ________________

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

______________________________ ______________________________

Please ***print*** name of Patient   Please ***sign*** for Patient / Guardian of Patient

______________________________ ______________________________

Legal Representative / Guardian   Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: ______________________________

____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA?

☐ First Name Only ☐ Proper Sir Name ☐ Other ________________________

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes stepparents, grandparents and any care takers who can have access to this patient's records):

Name: ________________________ Relationship: ____________________________

Name: ________________________ Relationship: ____________________________

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation   ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation   ☐ Email Confirmation
☐ Work Phone Confirmation   ☐ **Any of the Above**

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I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- ☐ Cell Phone Confirmation
- ☐ Home Phone Confirmation
- ☐ Work Phone Confirmation
- ☐ Text Message to my Cell Phone
- ☐ Email Confirmation
- ☐ **Any of the Above**

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- ☐ Phone Message
- ☐ Text Message
- ☐ Email
- ☐ **Any of the Above**
- ☐ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____

I could not communicate with the patient _____

The patient refused to sign _____

The patient was unable to sign because _____

Other (please describe) ____ ____

Signature of Privacy Officer