

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: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Male <input type="checkbox"/> 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?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	
Has your child complained about any dental problems?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	If yes, describe:
Any injuries or surgeries to the mouth, teeth, or head?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	If yes, describe:
Does your child still take the bottle or sippy cup?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	
Does your child brush daily?	<input type="checkbox"/> Yes   <input type="checkbox"/> 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?	<input type="checkbox"/> Yes   <input type="checkbox"/> No	
Does your child have any of the following habits?	<input type="checkbox"/> Thumb Sucking <input type="checkbox"/> Pacifier	<input type="checkbox"/> Finger Sucking <input type="checkbox"/> Grinding <input type="checkbox"/> Nail Biting
How does your child have any flu like symptoms or fever?	<input type="checkbox"/> yes <input type="checkbox"/> no	

## MEDICAL HISTORY

Allergies (Food, Drug, Dust, Additional) If Yes, Please list:	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Is your child currently taking any medications? If yes, please list:	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Rheumatic Fever/Rheumatic Heart Disease If Yes, is Pre-Med Needed? <input type="checkbox"/> Yes   <input type="checkbox"/> No	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Are your child's immunization's current?	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Diabetes TYPE 1 or TYPE 2 (circle one)	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Speech, Learning, or Hearing Disorders	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Convulsions, Seizures, Fainting, or Epilepsy	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Blood Transfusion	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Bruise Easily	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Asthma or Hay Fever	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Bleeding Disorder	<input type="checkbox"/> Yes   <input type="checkbox"/> No
High or Low Blood Pressure (circle one)	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Kidney or Bladder Problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Tuberculosis or other lung problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Pneumonia	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Liver Problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Heart Murmur, Mitral Valve Prolapse, Heart Defect	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Hepatitis, jaundice or other liver disease	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Heart Pacemaker	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Psychological or Emotional Problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes   <input type="checkbox"/> No
Kidney Disease	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes   <input type="checkbox"/> No
AIDS or HIV positive	<input type="checkbox"/> Yes   <input type="checkbox"/> No	Cancer/Tumor	<input type="checkbox"/> Yes   <input type="checkbox"/> 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: \_\_\_\_\_

## 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:

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

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

- |  |  |
|--|--|
| <input type="checkbox"/> Cell Phone Confirmation | <input type="checkbox"/> Text Message to my Cell Phone |
| <input type="checkbox"/> Home Phone Confirmation | <input type="checkbox"/> Email Confirmation            |
| <input type="checkbox"/> Work Phone Confirmation | <input type="checkbox"/> <b>Any of the Above</b>       |

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

- |  |   |
|--|---|
| <input type="checkbox"/> Phone Message | <input type="checkbox"/> <b>Any of the Above</b>            |
| <input type="checkbox"/> Text Message  | <input type="checkbox"/> <b>None of the above</b> (opt out) |
| <input type="checkbox"/> Email         |   |

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.

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**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