Shallotte
FAMILY DENTISTRY

Patient Information

Patient's Name_____ Preferred Name_____ Sex_____
(First) (Middle) (Last)

Date of Birth _____ Age_____ Weight _____ Patient's Social Security No. _____

Home Address_____
(Street) (City) (State) (Zip)

Home Phone_____ Cell Phone_____ Email: _____

Child lives with: Both Parents_____ Mother_____ Father_____ Other_____

In the event of an emergency, please contact _____
(Name) (Phone number) (Relation)

Our practice utilizes a text message service for appointment reminders and confirmations; as well as two way texting with our patients. Please note standard text message rates contracted through your cellular phone provider may apply.

Parent/Guardian Information

Mother's Name _____ Date of Birth _____ SS# _____ Marital Status_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer Name _____ Occupation_____

Father's Name _____ Date of Birth _____ SS# _____ Marital Status_____

Home Phone_____ Work Phone_____ Cell Phone_____

Employer Name _____ Occupation_____

Dental Insurance Information

Dental Insurance Name _____ Subscriber No. _____ Group No. _____

Name of Primary Subscriber _____ DOB: _____ Do you have a secondary dental insurance: ☐ Y ☐ N

Please provide the front desk with your dental insurance card and inform us of any changes to your dental insurance including secondary policies.

Financial Policy

As a courtesy to the patient we verify, file and process dental insurance and claims. If dental treatment is needed, we will estimate the patients' portion (co-pay) to the best of our knowledge based on the information provided to us by the insurance company. Copay and/or deductible are due, in full, the day of appointment. We cannot guarantee insurance will pay for any services based on eligibility as insurance does not guarantee payment. Therefore, any balance not paid by insurance within 30 days will then become the guardian's responsibility. A bill will be sent directly and the balance will be due immediately. Account balances must be paid in full in order to continue services with our practice. We accept credit card payment by phone using Discover, Visa or MasterCard and through our secure "Text to Pay" feature.

Cancellation Policy

Kindly provide 24 hour notice for appointment cancellations. Failure to provide adequate notice of cancellation will result in a broken appointment. After three broken appointments, the patient may be dismissed from our practice.

HIPPA Authorization

Please provide the name of the person(s) authorized to discuss your child's chart, schedule/cancel appointments, authorize treatment, and bring child to appointments. No information will be given to anyone who is not listed in this section or in the family chart.

Name _____ DOB_____ Relation to patient _____

Name _____ DOB_____ Relation to patient _____

Parent Name _____ Signature _____ Date: _____

PATIENT'S NAME: _____ DOB: _____ Weight: _____

MEDICAL HISTORY: ***Does your child currently have any of the following medical conditions?***

☐ Y ☐ N Acid Reflux/GERD
☐ Y ☐ N ADD/ADHD
☐ Y ☐ N Adverse Drug Reactions
☐ Y ☐ N AIDS/HIV Positive
☐ Y ☐ N Allergies/Seasonal Allergies
☐ Y ☐ N Anemia/Sickle Cell Anemia
☐ Y ☐ N Anxiety
☐ Y ☐ N Arthritis
☐ Y ☐ N Artificial Heart Valve
☐ Y ☐ N Asthma
☐ Y ☐ N Autism/Special Needs
☐ Y ☐ N Bleeding Disorder/Hemophilia
☐ Y ☐ N Bipolar
☐ Y ☐ N Bronchitis
☐ Y ☐ N Cancer: Type _____
☐ Y ☐ N Cerebral Palsy
☐ Y ☐ N Chemotherapy/Radiation
☐ Y ☐ N Cleft Lip/Palate
☐ Y ☐ N Cold sores/fever blisters/ulcers
☐ Y ☐ N Congenital Birth Defects
☐ Y ☐ N COPD
☐ Y ☐ N Crohn's Disease
☐ Y ☐ N Current Shingles
☐ Y ☐ N Depression
☐ Y ☐ N Diabetes: Type_____
☐ Y ☐ N Dialysis
☐ Y ☐ N Down Syndrome
☐ Y ☐ N Drug/Alcohol Abuse
☐ Y ☐ N Eating Disorder
☐ Y ☐ N Endocrine Growth
☐ Y ☐ N Endometriosis
☐ Y ☐ N Epilepsy/Seizures
☐ Y ☐ N Excessive Thirst
☐ Y ☐ N Fainting Spells/Dizziness
☐ Y ☐ N Frequent Cough
☐ Y ☐ N Frequent Infections
☐ Y ☐ N Gastro Intestinal Disease
☐ Y ☐ N Handicap/Disabilities
☐ Y ☐ N Hearing Impairment
☐ Y ☐ N Heart Surgery
☐ Y ☐ N Hepatitis: Type _____
☐ Y ☐ N HPV (Human Papilloma Virus)
☐ Y ☐ N Immune Suppressive Disorder
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Leukemia
☐ Y ☐ N Liver Disease
☐ Y ☐ N Lung Problems
☐ Y ☐ N Mental Disorder
☐ Y ☐ N MRSA
☐ Y ☐ N Nervous System Disorder
☐ Y ☐ N ODD (Oppositional Defiant Disorder)
☐ Y ☐ N OCD (Obsessive Compulsive Disorder)
☐ Y ☐ N Pain in Jaw Joints
☐ Y ☐ N Personality/Social Disorder
☐ Y ☐ N Physical Delays
☐ Y ☐ N Psychiatric Care
☐ Y ☐ N Recurrent Headaches
☐ Y ☐ N Renal Dialysis
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Sinus Trouble
☐ Y ☐ N Smoker/Vaping
☐ Y ☐ N Speech Disorder
☐ Y ☐ N STD/ Venereal Disease
☐ Y ☐ N Stomach/Intestinal Disease
☐ Y ☐ N Swelling of Limbs
☐ Y ☐ N Thyroid: Type _____
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Tumors/Growths

FEMALE PATIENTS
Are you pregnant? ☐ Y ☐ N
Are you nursing? ☐ Y ☐ N

Has your child experienced any other medical conditions not listed above? ☐ Y ☐N Please list: _____

Does your child require a premedication antibiotic prior to dental appointments? ☐ Y ☐N Is your child up to date on all vaccinations? ☐ Y ☐ N

Is your child in good health? ☐ Y ☐ N If No, please explain: _____

Is your child under the care of a physician? ☐ Y ☐ N Physician's Name: _____ Physicians Phone Number: _____

Has your child ever been hospitalized? ☐ Y ☐ N If Yes, please explain: _____

ALLERGIES: Is your child allergic to any of the following?

☐ Y ☐ N Amoxicillin
☐ Y ☐ N Aspirin
☐ Y ☐ N Clindamycin
☐ Y ☐ N Codeine
☐ Y ☐ N Dental Anesthetic
☐ Y ☐ N Eggs
☐ Y ☐ N Erythromycin
☐ Y ☐ N Latex
☐ Y ☐ N Penicillin
☐ Y ☐ N Red Dye
☐ Y ☐ N Sulfur
☐ Y ☐ N Tylenol/Acetaminophen

Is your child allergic to any other medications or foods that are not listed above? _____

DENTAL HISTORY:

Has your child ever had a bad experience in a dental office? ☐ Y ☐ N Please explain: _____

Name of previous dentist: _____ Practice Name: _____ Date of your last dental visit: _____

Does your child drink juice, soda or milk? ☐ Y ☐ N If so, how much a day and how often? _____

Has your child ever had a dental injury (bumped or chipped tooth, bruised lip)? ☐ Y ☐ N _____

What type of water source do you currently have? ☐ Private Well ☐City Water System ☐ Is your home water fluoridated? ☐ Y ☐ N

☐ Y ☐ N Does your child brush their teeth daily?
☐ Y ☐ N Does your child use dental floss?
☐ Y ☐ N Do you assist your child with brushing?
☐ Y ☐ N Does y our child grind or clench their teeth?
☐ Y ☐ N Does your child suck their thumb?
☐ Y ☐ N Does your child use a pacifier?
☐ Y ☐ N Does your child's gums bleed while brushing or flossing their teeth?
☐ Y ☐ N Does your child take a fluoride supplement?
☐ Y ☐ N Does your child bite their nails?
☐ Y ☐ N Does your child snack frequently?
☐ Y ☐ N Is your child currently nursing?
☐ Y ☐ N Does your child drink from a baby bottle or sippy cup?

MEDICATIONS: Please list all medications, vitamins and supplements your child is currently taking. If you have a list prepared please give this to the receptionist so it can be scanned into your chart.

Medication and Dose	*How much do you take and when?*	*What do you take it for?*	*Date started*

Is there any information we should know regarding your child's dental needs_____

By signing below I acknowledge I am the parent/legal guardian of the minor child named above. To the best of my knowledge, the information above is complete and correct. I understand it is my responsibility to inform the doctor if the patient has a change in health. I consent there are no court orders in effect that prohibit me from signing this form. I hereby authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays and administration of anesthetics and/or fluoride which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Parent Signature: _____ **Date**_____