New Patient Information

This record is confidential and for office use only. Thank you for completing this form in full.

I. Social History

Patient's full name____Preferred Name____________________
Age_______ Date of Birth ______________________ Sex___________ Patients SS#______________________________
Patient's Address____City______________________State________Zip_________
Child lives with: ☐ Both Parents ☐Mother ☐Father ☐Stepparent ☐Grandparent ☐Other__________________________
Child's favorite interest(s)____

~Mother's Full Name____SS#___________________________DOB__________
Mother's Address (if different from patient's) __________________________City___________________State_____Zip________
Mother's Employer____
Mother's Home #___________________________Cell #________________________Email_____________________________

~Father's Full Name____SS#___________________________DOB__________
Father's Address (if different from patient's)___________________________ City __________________State _____Zip________
Father's Employer____
Father's Home #_____________________________Cell #________________________Email_____________________________

~Emergency Contact (other than parent) ____Relationship____________________
Emergency Contact Home #____Cell #___________________________________

Name of your Child's Pediatrician____
Pediatrician's Telephone #____

Do you have any other children that are patient's here? ☐Yes ☐No
If so, names of other children____

Who may we thank for referring you (how did you hear about us)? Please check all that apply.

- ☐ Referred by Friend or Family: Name____
- ☐ Referred by General Dentist: Name____
- ☐ Referred by Pediatrician: Name____
- ☐ Upstate Parent Magazine
- ☐ Pine Street Elementary School Folders
- ☐ Website
- ☐ Community Event: Please specify ____
- ☐ Other: ____

II. Dental History

Reason for bringing your child to the dentist? ____
Approximate date of last dental visit____________________ What did child have done at that visit?______________________
☐ Yes ☐No Does your child frequently get sugary drinks or snacks between meals?
☐ Yes ☐No Do you brush your child's teeth before bed?
☐ Yes ☐No Does your child go to bed with a bottle or sippy cup?
☐ Yes ☐No Does your child use a pacifier or suck his/her thumb or fingers?
☐ Yes ☐No Has your child ever had an accident involving his/her teeth? If yes, please list__________________________
☐ Yes ☐No Has your child ever had surgery of any kind? If yes, please list_______________________________________
☐ Yes ☐No Is your child allergic to any drugs or Latex? If yes, please list_______________________________________
☐ Yes ☐No Has your child ever had hearing, sight, speech, or learning problems? If yes, explain_____________________
☐ Yes ☐No Does your child have a dental condition about which you are especially concerned? If yes, explain

____
What is your water source? ☐Private Well ☐City Water-Name of city____

III. Medical History:

Has your child ever been diagnosed as having any of the following conditions?

- ☐ AIDS
- ☐ Anemia
- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Brain Injury
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Cleft Lip/Palate
- ☐ Convulsions/Seizures
- ☐ Diabetes
- ☐ Diphtheria
- ☐ Eye Problems
- ☐ Excessive Bleeding Problems
- ☐ Fainting
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Hemophelia
- ☐ Hepatitis-Type _____
- ☐ Jaundice
- ☐ Luekemia
- ☐ Measles
- ☐ Mental Disability
- ☐ Mummps
- ☐ Mouth Breathing
- ☐ Nutritional Deficiency
- ☐ Orthopedic Problems
- ☐ Pneumonia
- ☐ Psychiatric Disorder
- ☐ Scarlet Fever
- ☐ Scoliosis
- ☐ Sick Cell Anemia
- ☐ Sinus Problems
- ☐ Snoring At Night
- ☐ Sore Throats – Frequent
- ☐ Spina Bifida
- ☐ Syndrome _________________
- ☐ Tetanus
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Other __________________

Is your child taking any medications at this time? Yes No
If yes, please list____

IV. Consent for Dental Treatment I acknowledge that the above mentioned information is correct, and I authorize Dr. Amanda Spivey Green and staff to provide dental and related medical/surgical treatment as deemed necessary utilizing proper and acceptable methods to complete same, including diagnostics radiographs and photographs.

Parent/Legal Guardian____Date_______________________

V. Permission to Photograph I grant Carolina Pediatric Dentistry the right to take photographs of my child. I authorize Carolina Pediatric Dentistry to use and publish the photo in print and/or electronically.

Parent/Legal Guardian____Date_______________________

VI. HIPAA Privacy Practices Notification I, the undersigned parent/legal guardian of ____________________________________ (print child's name), have been issued the HIPAA Notice of Privacy Practices. I fully understand that the Practice is required by law to maintain the privacy of my child's medical and health information. I acknowledge that the Practice will use and disclose my child's health information for the purposes of treating my child, obtaining payment for services rendered to my child, and conducting health care operations.

Parent/Legal Guardian____Date_______________________

VII. Authorization and Release To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk. Furthermore, I understand that it is my responsibility to inform this dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners as necessary. I hereby authorize Dr. Amanda S. Green, DMD of Carolina Pediatric Dentistry to perform the examination and after explanation, any and all treatment for the above-named child including radiographs if indicated and consent to such methods, drugs and agents that may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled. I agree to be responsible for payment of all services rendered on my behalf of my dependents. I understand that, as a condition of my child's treatment by this office, financial arrangements must be made in advance.

Parent/Legal Guardian____Date_______________________