Patient Basic Information

Patient Name: _____

Preferred Name: _____

Birth Date: _____ **Gender:** _____ **SSN:** _____

Patient Contact Information

Address: _____

Email: _____

Mobile Phone: _____

Patient Demographics

Employment Status: _____

Marital Status: _____

Language: _____

Ethnicity: _____

Race: _____

Primary Responsible Party Basic Information

Person Name: _____

Relationship: _____

Birth Date: _____ **Gender:** _____ **SSN:** _____

Primary Responsible Party Contact Info

Address: _____

Email: _____

Mobile Phone: _____

Primary Responsible Party Insurance

Insurance Carrier: _____

Group #: _____

Subscriber #: _____

Start Date: _____

Additional Information

Emergency Contact Name: _____

Relationship: _____

Phone: _____

Medical History

Is patient under care by a physician? □ Yes □ No

Patient's Physician: _____

Address: _____

Phone: _____

Date of Last Physical Exam: _____

Is the patient in good health? □ Yes □ No

Has there been any change in the patient's general health within the past year? □ Yes □ No

Has the patient had a serious illness, operation, or been hospitalized within the past 5 years? □ Yes □ No

If yes, please list: _____

Is patient receiving any prescription or over-the-counter drugs? □ Yes □ No

If yes, please list medication and dosage: _____

Has your child ever been hospitalized? □ Yes □ No

Has your child ever had surgery: □ Yes □ No

Has your child ever had blood transfusions: □ Yes □ No

Medical Conditions

Autism: □ Yes □ No

Cerebral Palsy: □ Yes □ No

Asthma: □ Yes □ No

ADD/ADHD: □ Yes □ No

Down Syndrome: □ Yes □ No

Heart Murmur: □ Yes □ No

Heart Conditions: □ Yes □ No

Please list any other physical or psychological conditions not listed:

Allergies

Is your child allergic to, or has your child had a reaction to any of the following? To all 'yes' responses, specify the type of reaction.

Local anesthetics: □ Yes □ No

Reaction: _____

Aspirin: □ Yes □ No

Reaction: _____

Penicillin/Other antibiotics: □ Yes □ No

Reaction: _____

Sulfa drugs: □ Yes □ No

Reaction: _____

Codeine/Other narcotics: □ Yes □ No

Reaction: _____

Metals: □ Yes □ No

Reaction: _____

Latex: □ Yes □ No

Reaction: _____

Iodine: □ Yes □ No

Reaction: _____

Animals: □ Yes □ No

Reaction: _____

Food: □ Yes □ No

Reaction: _____

Dental History

Date of Last Dental Visit: _____

Any previous unhappy medical or dental visits? □ Yes □ No

If yes, please explain:

Has the patient complained about sensitivity or any dental problems? □ Yes □ No

Does the patient use floss? □ Yes □ No

Does the patient brush daily? □ Yes □ No

Does the patient receive any assistance with brushing? □ Yes □ No

Has the patient ever had orthodontic treatment (braces)? □ Yes □ No

Has the patient had any problems associated with previous dental treatment? □ Yes □ No

How does the patient receive fluoride (i.e.)? □ Yes □ No

Any injuries to the mouth, teeth or head? □ Yes □ No

If yes, please specify where and time of occurrence:

Is the patient currently experiencing dental pain or discomfort? □ Yes □ No

Does the patient grind their teeth? □ Yes □ No

Does the patient have sores or ulcers in their mouth? □ Yes □ No

Previous Physician and Acknowledgement

Has a physician or previous dentist recommended that the patient take antibiotics prior to dental treatment? □ Yes □ No

Does your child have any diseases, conditions, or problems not listed above that you think our practitioners should be aware of? □ Yes □ No

If yes, please list:

NOTE: Both, doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above and the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Patient/Patient's Responsible Party Signature:

Print Name:

Date:

Consent

All children under 18 must be accompanied by a parent or legal guardian for their appointments. This includes new patient appointments (consults), six-month recall cleaning appointments, restorative appointments, and all orthodontic appointments. It is state law that a parent or legal guardian be present. If your child is brought by any other person they will be asked to reschedule. Further more, due to HIPPA regulations (confidentiality laws), we cannot discuss treatment with anyone other than a parent or legal guardian. Once patient turns 18 years of age we are no longer obligated to discuss treatment or account information with anyone but the patient.

I consent to the disclosure of patient records and or treatment information to the following persons who are involved in the patient's care or payment for that care.

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

My consent to disclosure of records shall be effective until I revoke it in writing.

Authorization and Release of Information

I agree that my dental insurance carrier may be billed for services provided and payment will be made directly to Goldsboro Pediatric Dentistry and Orthodontics. I also assume responsibility for any portion of the treatment cost not covered by my insurance carrier. I hereby give authorization for the release of any information requested or required by my insurance carrier with respect to any insurance claims.

I have read and understand the above.

Patient/Patient's Responsible Party Signature:

Print Name:

Date:

GPDO: Media Consent

I consent that Goldsboro Pediatric Dentistry and Orthodontics may use photographs or videos of me, taken on the date indicated below, on their social media tools which includes, but not limited to their Facebook page. I understand that these images and/or videos will not be used for any other commercial purposes. Photographs may also be printed and placed for display at our office.

If person(s) in photos/videos is a minor, please list name(s) below:

Patient/Patient's Responsible Party Signature:

Print Name:

Date: