Eastfield Pediatric Dentistry & Orthodontics

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PATIENT INFORMATION:

Name: _____ Birth Date: _____ Age: _____ Sex: F / M

Name: _____Birth Date: _____Age: _____ Sex: F / M

Address: _____ City:_____ State:_____ Zip:_____

(MOM) Home Phone:_____ Cellular: _____ Work:_____

(DAD) Home Phone: _____Cellular: _____ Work: _____

(MOM's) Email: _____ (DAD's) Email: _____

Do we see siblings? No ( ) Yes ( ) If yes list names: _____

Whom may we thank for referring you to our office? _____

PARENT/GUARDIAN INFORMATION:

Responsible party name: _____ Relationship to patient: _____

D.O.B _____ S.S # _____ _____ _____

Address: _____ City:_____ State:_____ Zip: _____

INSURANCE: ***As a courtesy, we will verify your benefits and we accept assignment of benefits from most insurance companies. In order to do so you must provide us with the following information:***

Do you have Dental Insurance? Yes ( ) No ( )

Do you have more than one dental insurance? Yes ( ) No ( )

Name of person insured: _____ Relationship to patient:_____

D.O.B _____ S.S.# _____ ____ _____ Ins ID # _____

Place of Employment: _____ Insurance Company: _____
Insurance Phone Number: _____ Group #: _____
Claims mailing address: _____ City _____state_____ Zip _____
Secondary Ins. Name:_____ ID or SS #_____ Group # _____
Phone # _____ Name of Policy holder: _____ D.O.B _____

Eastfield Pediatric Dentistry & Orthodontist
8631 Arbor Creek Drive, Suite D-3
Charlotte, NC 28269

(704) 875-90
office@eastfieldpd.c

Medical History

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Child's Physician Name and Phone

_____

Is your child in good general health?

◯ Yes ◯ No

If no, please describe.

_____

Does your child have any physical disabilities/developmental delays?

◯ Yes ◯ No

If yes, please describe.

_____

Are your child's immunizations and booster shots up to date?

◯ Yes ◯ No

Has your child had any surgical operations?

◯ Yes ◯ No

If yes, for what?

_____

Has your child ever been hospitalized?

◯ Yes ◯ No

If yes, for what?

_____

Please check any medical alerts that may apply to your child:

☐ Abnormal Bleeding	☐ ADD/ADHD	☐ Allergy - Aspirin	☐ Allergy - Codeine
☐ Allergy - Erythro	☐ Allergy - Hay Fever	☐ Allergy - Latex	☐ Allergy - Other
☐ Allergy - Penicillin	☐ Allergy - Sulfa	☐ Anemia	☐ Arthritis
☐ Artificial Joints	☐ Asperger's Syndrome	☐ Asthma	☐ Autism Spectrum
☐ Birth Defects	☐ Blood Disease	☐ Cancer	☐ Cleft Lip/Palate
☐ Convulsions	☐ Diabetes	☐ Dizziness	☐ Ear/Nose/Throat Prob
☐ Eating Disorder	☐ Epilepsy	☐ Hearing Impairment	☐ Heart Murmur
☐ Heart Trouble	☐ Hepatitis	☐ Herpes Virus	☐ High/Low Blood Press
☐ HIV/AIDS	☐ Jaundice	☐ Kidney Disease	☐ Liver Disease
☐ Mumps	☐ Nervous Disorders	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Rheumatism	☐ Scarlet Fever	☐ Sensory Integration	☐ Shingles
☐ Sinus Problems	☐ Steriods	☐ Stomach Ulcers	☐ Thyroid Problems
☐ Transfusions	☐ Tuberculosis	☐ Vision Impairment	

If your child has allergies, please list the specific seasonal, food or drug allergy:

Has your child had any history of asthma or breathing problems?

◯ Yes ◯ No

Has your child been to the ER for an asthma attack?

◯ Yes ◯ No

What induces the breathing problems?

What asthma medication does your child take?

Please list any current medications your child is taking, including how often they are taking it and the reason they are taking it.

Please check if your child has problems with any of the following:

☐ Speech ☐ Hearing ☐ Vision

Do you consider your child to be:

☐ Advanced in learning ☐ Progressing normally ☐ A slow learner

Child's first language:

Second or other languages:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status. I authorize the dentist to release an information, including the diagnosis and records of any treatment or examination rendered to my child during period of such dental care to third party payers and/or health practitioners.

Signature: _____ Date: _____

Response Date: _____

Authorization for Release of Information to Family and/or Friends

Name of Patient: _____ Date of Birth: _____

Eastfield Pediatric Dentistry & Orthodontics is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

Entity to Receive Information. CHECK EACH that is subject to this authorization.

_____ Voicemail.
_____ Email communication-Provide email:* _____
_____ Text communication-Provide number:* _____
* Email and/or Text communications are not SECURE if not Encrypted

Description of information to be released

_____ Appointment Reminders.
_____ Financial information. Bills and/or Balances.
_____ Medical information as follows: _____
_____ Results from test or x-rays.
_____ Other information as described: _____
_____ Patient's photo taken at the office (Example: at registration, pre/post procedure, etc.)
_____ Patient's photo may be posted on website and/or social media. ◯ Yes ◯ No

Entity, Family, Friend to Receive Information

_____
Name/Relationship of person(s) to bring patient(s) to appointment

_____
Name/Relationship of person(s) to release information to, per this authorization form

Patient Information

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that the information used or disclosed as a result of this authorization may be subject to re disclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned upon signing this authorization.

This Authorization shall be in force and effect until revoked by the patient or representative signing the authorization.

_____ _____
Signature of Patient or Personal Representative Date

_____
Description of Personal Representative's Authority (attach all necessary documentation)