CHARLOTTE PEDIATRIC DENTISTRY

We're in the Business of Children's Smiles

www.CltPediatricDentistry.com

New Patient Information

Today's Date _____

1 Child's Information

_____

Last Name First Name Middle Name Name Child Goes By

Address _____ City/State/Zip _____

Telephone Numbers: Home _____ Cell _____ Date of Birth ____/____/____

Place of Birth: _____ Sex: ☐ M ☐ F Age _____ Weight _____ Height _____

Favorite Hobbies/Interests _____

Name of School or Day Care _____

Child Lives With: ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____
(If Other, please fill in relationship to child)

Have you traveled outside the U.S. in the past 12 months?: Y N Where? _____

Names and ages of Brothers/Sisters: _____

Child's Physician _____ Telephone Number _____

When was your child's last physicians visit? _____

How did you find out about our office? _____

2 Responsible Party Information

Mother/Guardian Name _____ Date of Birth _____
(If different than above)

Address/City/State/Zip _____ Home/Cell Number _____

Email Address _____ SS # _____

Employer _____ Occupation _____ Work Number _____

Father/Guardian Name _____ Date of Birth _____
(If different than above)

Address/City/State/Zip _____ Home/Cell Number _____

Email Address _____ SS # _____

Employer _____ Occupation _____ Work Number _____

Emergency Contact Name (Friend/Relative not living with you) _____

Home/Cell Number _____ Address/City/State/Zip _____

3 Insurance Information

Primary Insured's Name _____ Relationship to Child _____

Insured's: SS # _____ Date of Birth ____/____/____ Group Policy # _____

Name of Insurance Co. _____ Telephone _____

Primary Insured's Employer _____ Telephone6 _____

3 Insurance Information (continued)

Child's Name _____ Date of Birth _____

I hereby authorize payment of the dental benefits otherwise payable to me to be paid directly to David H. Moore, DDS, MS, PA. *I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.*

Signature of the Insured _____ Date _____

4 Medical History

Has your child ever had any of the following medical problems? (Circle appropriate response)

Y N Allergies
Y N Anemia or Blood Disorders
Y N Asthma or Hay Fever Please indicate type and current medications: _____
_____
Y N Autism
Y N Bladder/Kidney Problems
Y N Bleeding/Bruises Easily
Y N Blood Transfusion
Y N Blood Pressure, High/Low
Y N Bronchitis
Y N Cancer/Chemotherapy
Y N Cerebral Palsy
Y N Congenital Heart Defect If yes, are Premed needed? Y N
Y N Convulsions/Seizures, Fainting or Epilepsy
Y N Childhood Illnesses
Y N Diabetes
Y N Down Syndrome
Y N Handicap, Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hepatitis, Liver Problems
Y N HIV/AIDS
Y N Learning Disorder
Y N Psychological, Emotional Problems
Y N Rheumatic Fever
Y N Speech Disorder
Y N Tuberculosis

Is child allergic to any of these drugs: ☐ Penicillin ☐ Amoxicillin ☐ Erythromycin ☐ Codein ☐ Dental Anesthetic

Is child allergic to any other drugs? Y N If yes, please list: _____

Is child allergic to: ☐ Latex ☐ Red Dye ☐ Eggs ☐ Nuts ☐ Drug ☐ Other, please list:

Are child's immunizations current? Y N Please explain: _____

List any drugs or medications child is currently taking: _____

_____

5 Dental History

Date of last Dental visit _____ Name of Dentist _____

Do you have current Records (including x-rays) from another practice? Y N

Has child complained about any dental problems? _____

Any injuries or surgeries to mouth, teeth, head? Y N If yes, please describe: _____

_____

Does child still take a bottle or sippy cup? _____ What does child usually drink? _____

Does child brush daily? Y N How often? _____ Do you assist child with brushing? Y N How often? _____

Is Dental Floss used? Y N

Please check each box if child has any of the following mouth habits: ☐ Thumb Sucking ☐ Mouth Breathing ☐ Pacifier ☐ Nail Biting ☐ Finger Sucking ☐ Grinding ☐ Other: _____

How does your child receive Fluoride?

☐ Water Supply ☐ Dentist ☐ Toothpaste ☐ Vitamins ☐ Tablets ☐ None ☐ Other: _____

What is child's attitude towards Dentistry? _____

Reason for today's visit and your chief concerns: _____

_____

I hereby certify that all of the above information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. Furthermore, I will be responsible for any professional fees incurred for dental services for my child. I understand that I am responsible for all charges whether or not covered by insurance. All balances over 30 days are subject to a 1.5% per month finance charge.

Signed _____ Date _____

Relationship to Child _____