

Authorization to Release Health Information To a Health Care Provider

Patient Information:

Name of Patient: _____ Date of Birth: _____

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Name & Address of Covered Entity authorized to release information:

Forward Information to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Call Parent when records are ready for pick-up at () _____

Description of Records Needed:

Most Recent x-rays

Other _____

Reason for Leaving: _____

This authorization shall be in effect for 60 days from date of signature. David H. Moore, DDS, MS, PA will only forward documents deemed necessary per each instance. Please contact one of our offices if you need any further records.

Rights of the Patient

- I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.
- I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to David H. Moore, DDS, MS, PA.

Signature of Patient or Personal Representative Date

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



David H. Moore, DDS, MS, PA

Specialists in Pediatric
Dentistry and Orthodontics



Cotswold/Midtown

411 Billingsley Rd.
Suite 106
Charlotte, NC 28211
Tel 704-377-3687
Fax 704-377-9790

OUR OFFICE LOCATIONS

University

10320 Mallard Creek Rd.
Suite 150
Charlotte, NC 28262
Tel 704-547-8438
Fax 704-547-9323

Davidson

130 Harbour Place Dr.
Suite 180
Davidson, NC 28036
Tel 704-896-8100
Fax 704-896-8787



Patient Information

Child's Full Name _____ Name Called By _____

Age _____ Birthday _____ / _____ / _____ Sex: M____ F____ Place of Birth _____

Child's Home Address _____

City _____ State _____ Zip Code _____ Home Phone () _____

Child's Favorite Hobbies/Interests _____

Name of School/Day Care _____

Brothers (Names & Ages) _____

Sisters (Names & Ages) _____

Child's Physician _____ Phone () _____

Address _____ Date of Last Exam _____

What is your Child's Current Weight? _____ What is your Child's Current Height? _____

Parent/Guardian Information

Parent/Guardian Name _____ Relationship to Patient: _____

Social Security # _____ - _____ - _____ Date of Birth: _____

Employer _____ Work/Mobile Phone () _____

Parent/Guardian Name _____ Relationship to Patient: _____

Social Security # _____ - _____ - _____ Date of Birth: _____

Employer _____ Work/Mobile Phone () _____

Marital Status Married Divorced Widowed Separated Partner Other

Email Address _____

How did you find out about our office? _____

Emergency Contact/Friend or Relative Not Living with You

Name _____ Phone () _____

Address _____ Zip Code _____

Insurance Information

Insured's Name _____ Relationship to Patient _____

Insured's Date of Birth _____ Insured's Employer _____

Name of Insurance Company _____ Group Number _____

I have received the following treatment plan and fees. 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 portion of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

Signature of Insured

Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to David H. Moore, DDS, MS, PA.

Signature of Insured

Date



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Medical History

Please indicate with a YES or NO. Does your child currently have/previously had any of the following health problems?

- _____ Allergies (Latex, Penicillin, Eggs, Nuts, Food, Dust, Drug, Unknown) If yes, Please List _____
_____ Rheumatic Fever / Rheumatic Heart Disease _____ Congenital Heart Disease or Heart Murmur
If yes, Premed Needed? _____ Name of Pharmacy: _____ Pharmacy Phone Number: _____
_____ Glandular or Hormonal Problems _____ Diabetes/Blood Sugar Problems _____ Arthritis or Rheumatism (painful, swollen joints) _____ Convulsions, Seizures, Fainting or Epilepsy _____ Anemia or Blood Disorders _____ Asthma or Hay Fever (Please Indicate) If yes, please list any current medications: _____

Are your child's Immunizations Current? _____
Does your child have any special needs or special circumstances? (i.e. Autism, Cerebral Palsey, Downs Syndrome): _____

Dental History

- Date of Last Dental Visit _____ By Dr. _____
Do you have any Current Records (including x-rays) from another practice? Yes No
Has your child complained about any dental problems? _____
Any injuries or surgeries to mouth, teeth, head? Yes No If yes, please describe _____
Does your child still take the bottle or sippy cup? _____
What does your child usually drink? _____
Does your child brush daily? Yes No How Often? _____
Do you assist your child w/Brushing? [] Yes [] No How Often? _____
Is Dental Floss used? [] Yes [] No

Please check each box if your 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: _____

Child's Attitude Towards Dentistry: _____
Reason for Today's Visit/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 Patient _____