



NEW PATIENT INTAKE FORM

Thank you for ensuring a legal guardian for the child completes this form thoroughly. By doing so, you are assisting us in providing the most friendly, safe, and efficient care for your child!

How did you hear about us? Check all that apply and list your referral or friend's name so we can thank them!

Google Search Facebook Instagram Referring doctor Family/Friend: _____ Other: _____

CHILD'S DEMOGRAPHIC INFORMATION

Today's Date: _____

First Name: _____ MI: _____ Last Name: _____

Preferred Name: _____ Birthday: _____ Age: _____ Sex: _____

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

Phone for Appt Reminders: _____ Name of School/Daycare: _____ Grade: _____

Child Lives with: _____ Siblings' Names & Ages: _____

Please provide the following information if the patient is under 18 years of age or has a legal guardian:

Parent/Guardian #1: _____ DOB: _____ Email: _____

Mobile Phone: _____ Home: _____ Work: _____ Employer: _____

Relationship to Child: _____ SSN: _____ Legal Custody of Child Y N

Same address as child? Yes No, my address is: _____

I authorize patient photos to be sent to me by email at the address listed above

Parent/Guardian #2: _____ DOB: _____ Email: _____

Mobile Phone: _____ Home: _____ Work: _____ Employer: _____

Relationship to Child: _____ SSN: _____ Legal Custody of Child Y N

Same address as child? Yes No, my address is: _____

I authorize patient photos to be sent to me by email at the address listed above

Emergency Contact: _____ Phone: _____ Relationship to Child: _____

Person Responsible for Payments on Account: _____

If different from parent/guardian above:

Relationship to Child: _____ DOB: _____ SSN: _____

Mobile Phone: _____ Home: _____ Work: _____ Employer: _____

Reason for your child's dental visit: _____

Additional comments or questions you may have: _____

Sometimes we make conversation by talking about upcoming holidays, cartoon characters, tooth fairy, etc. Is this OK with you? Yes No

What is a favorite something we can talk to your child about to make him/her comfortable? _____



CHILD'S DENTAL HISTORY

Patient Name: _____

Is this your child's 1st dental visit? Yes No → Who saw your child? When? How did it go? _____

Has your child had dental x-rays in the past six months? No Yes

Do you have concerns about your child's dental health? No Yes → Please describe: _____

Is your child currently experiencing any dental problems? No Yes: _____

Do you give consent for fluoride at your child's first visit with us? Yes No

Do you give consent for dental radiographs if needed at your child's first visit with us? Yes No

How often are your child's teeth brushed? _____

Does your child use fluoridated toothpaste? No Yes

Does an adult assist your child with brushing? No Yes → How often? _____

Does an adult assist your child with flossing? No Yes → How often? _____

Do your child's gums bleed when brushed? No Yes

Does your child drink city water? No Yes

Was your child breastfed? No Yes → If stopped, at what age? _____

Which of the following drinks and food does your child consume *daily*? Check all that apply:

- Gatorade/Sports drinks Juice Soda/energy drinks Bottled water Tap water Milk Flavored milk Sparkling water
- Dried fruit/raisins Cereal or granola bars Gummies/vitamin gummies Fruit snacks/fruit roll-ups Cookies/crackers

Has your child experienced any of the following? If the habit has stopped, please specify at what age: _____

- Pacifier use Finger sucking Thumb sucking Nail biting Other: _____

Has your child ever worn an orthodontic appliance? No Yes

Does your child experience clicking or popping in the jaw (TMJ/TMD)? No Yes

Does your child wear a mouthguard for sports? No Yes

Does your child get cold sores or fever blisters? No Yes *Please explain:*

Does anyone in the family get cold sores or fever blisters? No Yes → _____

Does anyone in the family have missing teeth? No Yes → _____

Has your child inherited any dental conditions that you know of? No Yes → _____

Has your child had a dental injury (bumped/chipped tooth, bruised lip, etc.)? No Yes → _____



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CHILD'S HEALTH HISTORY

Patient Name: _____

Is your child under the care of a medical doctor at this time? No Yes → Last Medical Exam: _____

Name of Pediatrician/Clinic: _____ Are your child's immunizations current? Yes No

Has your child ever been hospitalized? No Yes →

Has your child received general anesthesia? No Yes →

Has your child had any excessive bleeding requiring special treatment? No Yes →

Has your child ever been diagnosed with a heart condition or heart murmur? No Yes →

If you answered yes to any of the four previous questions, please describe the reason or procedure and any complications: _____

Do you or your child use tobacco products? No Yes

Is your child adopted? No Yes → At what age? _____

Was the pregnancy and delivery without complications? Yes No → Please explain: _____

Does your child have any **allergies**? Check all that apply:

Food allergy Ibuprofen/Motrin Lanolin Penicillin Rubber/Latex Seasonal Silver Sulfa Wool Other: _____

Please list any **medications** your child is currently taking, including vitamins/supplements or holistic remedies: _____

Has your child taken any medications or drugs in the past two years? No Yes → _____

Does your child have any medical conditions? Check all that apply:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stomach problems |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Eczema/psoriasis | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Head injury | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Autism spectrum disorder | <input type="checkbox"/> Hearing impairment | <input type="checkbox"/> Mouth breathing | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Heart condition | <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Nutrition deficiency | <input type="checkbox"/> Vision impairment |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Psychiatric disorder | <input type="checkbox"/> Pregnant: Due date? _____ |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Cancer: Type? _____ |
| <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sickle cell anemia | <input type="checkbox"/> Chemotherapy: When? _____ |
| <input type="checkbox"/> Cystic fibrosis | <input type="checkbox"/> Intellectual disability | <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Radiation: When? _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Snoring | <input type="checkbox"/> Stroke: When? _____ |
| <input type="checkbox"/> Dizzy spells or fainting | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Spina Bifida | <input type="checkbox"/> Other: _____ |
- Epilepsy or seizures: Last seizure? _____ Frequency? _____ Medication? _____
- Asthma: Last attack? _____ Frequency of inhaler use? _____ Rescue inhaler with you? _____

I understand that providing inaccurate information can be dangerous to my child's health. I certify that I have read and understand the above information. I acknowledge that I have answered the above questions correctly and that to the best of my ability, and that any questions that I had have been answered to my satisfaction. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Print Name of Legal Guardian: _____

Relationship to Child: _____

Signature: _____

Date: _____

Pediatric Dentist's Signature: _____

Date: _____



PATIENT ADVISORY AND ACKNOWLEDGEMENT: Receiving Dental Treatment During the COVID-19 Pandemic

Patient Name: _____ **Date of Birth:** _____

You have visited Carolina Pediatric Dentistry for dental services during the COVID-19 pandemic. Please be advised of the following: Our office follows infection control recommendations made by the American Dental Association (ADA), the U.S. Centers for Disease Control and Prevention (CDC) and the Occupational Safety and Health Administration (OSHA). We are considered an essential service and follow strict guidance from the North Carolina State Dental Board of Dental Examiners. Our team attests, to the best of their knowledge, they have not been exposed to COVID-19. All uniforms are laundered on-site, and shoes stay within the premises. We are minimizing the number of persons and interactions between persons at any one time in for best practices in risk mitigation. We are asking all who enter to wash hands upon entry/exit and all individuals over the age of two (2) to wear a mask. Since we are a place of public accommodation, other persons (including other patients) could be infected, with or without their knowledge.

Please answer these screening questions to ensure the health and safety of your child, the children, and families we serve, as well as our team at Carolina Pediatric Dentistry:

- Unwell with ANY of the following symptoms: fever $>100.4^{\circ}\text{F}$ in the last 24-48 hours, dry cough, sore throat, difficulty breathing, runny nose, nausea/vomiting, diarrhea, loss of smell/taste, unexplained rash, or headaches?
 - You (legal guardian)?** No Yes
 - Your child?** No Yes
- Been in close contact* with an individual with 1) confirmed Coronavirus COVID-19 infection, 2) symptoms consistent with COVID-19, OR 3) anyone pursuing a COVID-19 test?
 - You (legal guardian)?** No Yes
 - Your child?** No Yes

*Close contact defined as being coughed/sneezed on, or interacting within 6 feet of a symptomatic or COVID-19 positive person without a face covering for >10 minutes

I understand Carolina Pediatric Dentistry's efforts are intended to minimize spread of COVID-19. I understand my child and my own risk of exposure to the coronavirus cannot be eliminated when we leave the safety of our home. **I pledge to contact Carolina Pediatric Dentistry if my child or I develop symptoms consistent with COVID-19 or are confirmed positive to COVID-19 within the 48 hours following our visit.**

Parent/Guardian

Date



REQUEST AND CONSENT FOR DENTAL TREATMENT

A legal guardian must complete this form. Please read this form carefully. If you do not understand something to your satisfaction, please ask us for clarification.

1. I request and authorize dental treatment for my child by Dr. Johnson, Dr. Morris, and team.

Patient Name: _____ **Date of Birth:** _____

2. I am the legal guardian of the child named above. _____(Initials)

3. **I understand** that I will have sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment by Dr. Johnson, Dr. Morris, and team.

3a. I further request and authorize the taking of dental x-rays, the use of topical and local anesthetic, the use of fluoride, and the use of nitrous oxide/oxygen as may be considered necessary to treat my child's dental need(s).

3b. **I understand** that all of my questions will be answered to my satisfaction, and I consent to the treatment and procedures prescribed for the patient on the treatment plan. **I understand** that I may revoke this consent to treatment at any time, and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

4. It is unusual but is possible for any of the following risks or complications to occur, including not limited to: the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

5. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted prior to initiation of treatment procedures not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives at Carolina Pediatric Dentistry.

6. **I understand** it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion, humor, charm, gentleness and kindness and understanding. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

7. **I understand** that should my child become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and or doctor to hold a patient's hands, stabilize the head and/or control leg movements for their safety. I also understand the routine use of "tooth pillows" (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their

mouth that could harm them. I also understand that mouth props are sometimes necessary if a child refuses to open his/her mouth. _____ (Initials)

7a. **I understand** that it is a common response for children to cry before or during dental treatment or directly afterward when they see their parent. **I understand** the only way I can guarantee my child will not cry or be unhappy during dental treatment is if I elect to have his/her treatment completed in the operating room under general anesthesia.

7b. **I further understand** that should my child become uncooperative during dental procedures with excessive body movements, the patient may need to be wrapped in a “hug blanket” called a Pedi-Wrap to prevent injury and enable Dr. Johnson and/or Dr. Morris to safely provide the necessary treatment. *I will be consulted prior to the use of the Pedi-Wrap.*

8. In accordance with the Federal Privacy Law, **I understand** that personal electronic devices are prohibited in patient care areas. **I understand** that CPD team members may use a designated clinic camera to take patient HIPAA-compliant photos for me at my request.

9. For the purpose of advancing medical-dental education, **I give permission** for the use of clinical photographs, video and/or radiographs of the patient for diagnostic, scientific, educational, certification or research purposes.

10. **I authorize** the taking of photographs of my child with a designated clinic camera for marketing and advertising purposes (i.e. website, Facebook, Instagram, print materials, etc.): Yes No

11. **I give permission** for my child to watch **any Disney animated movie rated G or PG**: Yes No

12. **Family Behavior Policy: I understand** CPD has a “no tolerance” policy for the following: abusive conduct, profanity/cussing, crude graphics, threatening, or aggressive behavior, and/or larceny. This applies to patients, other family members/visitors, CPD team and pediatric dentists. There are no further warnings, second chances or exceptions for a violation. A violation will result in immediate transfer of care to a new dental home of my choice. I am committed to keeping this a wholesome, family-friendly environment for impressionable young children.

13. **Immunization Policy: I understand** that CPD requires up-to-date immunizations for every team member, pediatric dentist, and patient of record unless documentation from a medical provider is submitted detailing medical reasons otherwise. I understand leaving the safety of my home increases my child’s risk and my own risk of contracting transmissible diseases for which there are no vaccines including Covid-19 infection from Sars-CoV-2.

14. **I confirm** that I am a legal guardian to the child referenced on the opposite page. **I also confirm** that I have read this form or it was read to me, and I understand this form. **I also confirm** that all blanks were filled in and any paragraph that does not apply was stricken before I signed below.

Signature of Person Consenting to Treatment/Relationship to child

Date

Signature of Doctor

Date

Witness Certification

Date



NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

I have read and understand Carolina Pediatric Dentistry's Notice of Privacy Practices. Specifically, I understand that my protected health information will be used to:

- Conduct, plan and direct my (or my child's) treatment and follow-up among other healthcare providers who may be involved in that treatment
- Obtain payment (e.g. insurance companies, collection agencies, check processing companies)
- Conduct normal healthcare operations such as quality assessment

I also understand that the usual business practice of this office is to use an open bay for most treatment and to call or text to confirm appointments prior to most appointments. Please check the appropriate boxes below if you want something other than our usual business practice:

- Do not use an open bay for patient treatment. Schedule all appointments for the VIP room. I understand that this may limit my ability to schedule appointments as there is only one private treatment room in this office.
- Do not call to confirm appointments. I understand that missing appointments may result in dismissal from the office.
- Do not text to confirm appointments. I understand that missing appointments may result in dismissal from the office.
- Do not email to confirm appointments. I understand that missing appointments may result in dismissal from the office.

Patient Name: _____

Caregiver Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____



AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ **Date of Birth:** _____

Entity to receive information. Indicate each person/entity that you approve to receive information.	Description of information to be released. Check each box below if person/entity on the left can receive that type of information
<input type="checkbox"/> Email _____ <input type="checkbox"/> Cell Phone _____ <input type="checkbox"/> Voice Mail _____	<input type="checkbox"/> Pre-Med <input type="checkbox"/> Other _____
Name(s) of Parents: _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
Name(s) of Grandparent/Relative/Other Caregiver: _____ _____	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Can Sign for Treatment
When coordinating treatment with fellow providers, please check the box to the right to authorize emailing x-rays.	<input type="checkbox"/> Check here for <u>email</u> authorization (this is secured email). I understand while extremely rare, it is possible for email to be viewed by others.
Name of Pediatrician/Primary Care Physician so we may send a follow up letter regarding patient's dental visit: _____	<input type="checkbox"/> Check here for <u>fax and email</u> authorization (this is secured email). I understand while extremely rare, it is possible for email to be viewed by others.

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 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 on signing. This authorization shall be in effect until revoked by the patient.

Signature of Patient or Personal Representative _____

Date _____

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

OFFICE USE ONLY

I attempted to obtain the patient's (or parent's) signature in acknowledgement of this Notice of Privacy Practices, but I was unable to do so as documented.

- Patient or parent was given notice but forgot sign before leaving the office.
- Patient or parent refused to sign.
- Notice was mailed to patient or parent.

Team Member Signature and Date: _____