New Patient Forms

Welcome!

How did you hear about our office? ____

Whom may we thank for referring you? ____

Sections in italics are needed for EACH patient. All other sections may be used for multiple patients given their name is disclosed in the requested fields. Information in BOLD is Required. If paperwork is incomplete we reserve the right not see the patient.*

Patient Information: **Date:** _______________

Patient's Full Name: ____

Child's Home Address: ____

City: ____________________________________ **State:** __________ **Zip:** ____________________

Home# ( )__________ Cell #( )___________ Alt#( )____________E-Mail: __________________

DOB: _________________________ **Sex: Male/Female Nickname:** ___________________________

Health History:

Previous Dentist:_____________ **Last dental visit:** ___________ **x-rays? yes/no fluoride? yes/no**

Name of child's physician: ______________________________ Phone #: __________________

It is required that we have pediatrician information on file*

Has your child had any health concerns? If so, please explain: ______________________________

Has your child ever been hospitalized? If so, please explain: _______________________________

Is your child allergic to anything? If so, please explain: _________________________________

Does your child experience excessive bleeding? If so, please explain: ______________________

Is your child taking any medications? If so, please explain: ______________________________

Were there any health concerns at birth? If so, please explain: ______________________________

Please circle if your child has been treated for any of the following:

Heart Disease	Y/ N	Blood Dyscrasias	Y/ N	Rheumatic Fever	Y/ N	Fainting	Y/ N
Diabetes	Y/ N	Speech/Hearing Delays	Y/ N	Physical Delays	Y/ N	Congenital Birth Defects	Y/ N
Measles/Mumps	Y/ N	Drug/Alcohol Abuse	Y/ N	Bleeding/Transfusions	Y/ N	Tuberculosis	Y/ N
Anemia	Y/ N	Kidney Disease	Y/ N	Mental Delays	Y/ N	Seizures/Epilepsy	Y/ N
ADD/ADHD	Y/ N	Thyroid Disease	Y/ N	Cancer/Tumors	Y/ N	Frequent Infections	Y/ N
Liver/GI Disease	Y/ N	Asthma	Y/ N	Rheumatic Fever	Y/ N	Fainting	Y/ N
Cleft lip/palate	Y/ N	Bladder Difficulty	Y/ N	Cerebral Palsy	Y/ N	AIDS/HIV	Y/ N
Hepatitis	Y/ N	Personality/Social Disorder	Y/ N	Headaches	Y/ N	Other_____________	Y/ N

Highlighted areas will require a medical clearance

Other: ____

Please explain any of the above circled conditions: ___________________________________

____

11010 S. Tryon Street Suite 101 Charlotte, NC 28273
704.587.7336(p) 704.587.7579 (f)
www.youngandpolite.com youngandpolite@gmail.com

Parent/Guardian Information:

Does the following information apply to any siblings? ___ If so, please list:

Name of Patient: ______________________________ DOB: ______________

Name of Patient: ______________________________ DOB: ______________

Name of Patient: ______________________________ DOB: ______________

Father's Name: ______________________________ Marital Status: ____________

Address (if different from above): ______________________________

City: ______________________ State: __________ Zip: ______________

DOB: ______________________ **Social Security #:** ______-______-______

Home #: ______________ Cell #: ______________ Work: __________x______

Email Address: ______________________________

Mother's Name: ______________________________ Marital Status: ____________

Address (if different from above): ______________________________

City: ______________________ State: __________ Zip: ______________

DOB: ______________________ **Social Security #:** ______-______-______

Home #: ______________ Cell #: ______________ Work: __________x______

Email Address: ______________________________

It is required that we have at least one guardian's SS# on file

Insurance Information:

Does the following information apply to any siblings? ___ If so, please list:

Name of Patient: ______________________________ DOB: ______________

Name of Patient: ______________________________ DOB: ______________

Name of Patient: ______________________________ DOB: ______________

Insurance Company Name: ______________________________

Subscriber Name: ______________________ **Employer**: ______________________

ID/SS#: ______________________ **Group #:** ______________________ **DOB**: ______________

Insurance Mailing Address: ______________________________

City: ______________________ State: ______ Zip: ______________

I certify that my minor/child is covered by insurance with (insurance company name) ______________ and I assign all insurance benefits directly to Young & Polite Children's Dentistry, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance**. I herby authorize the doctors to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. *I understand that Young & Polite Children's Dentistry* ***require a 48 hour notice*** *for all appointments needing to be cancelled and/or rescheduled.* Less than **48 hours** notice is considered a broken/missed appointment. ***I also understand that more than two broken/missed appointments may result in dismissal from the practice.*** Any appointment cancelled the same day or missed without prior notice will be subject to a $75 fee. I understand that I am to arrive **10 minutes** prior to my scheduled appointment time to take care of any administrative needs associated with my child's treatment. I understand that the Clinical Director reserves the right to reschedule my appointment for late arrivals.

Signature of Legal Guardian*: ______________________________ **Date:** ______________

How May We Contact You?:

Does the following information apply to any siblings?___ If so, please list:

Name of Patient: ____ DOB: _______________

Name of Patient: ____ DOB: _______________

Name of Patient: ____ DOB: _______________

Young & Polite Children's Dentistry is authorized to release protected health information about the above named patient(s) to the entities named below. The purpose is to keep communications within the patient/parent/guardian's instructions (check if yes, leave blank if no)

May we leave voicemails regarding appointments? _____ **emails? _____text messages? _____**

May we leave the above messages regarding sensitive financial or medical information? ___________

May we release information to anyone other than yourself? ___ If so, who? ______________________

I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected Initials of Legal Guardian __________________Date____________________

***Name of Individual(s) authorized to bring child(ren) to appointments (must be at least 21 years of age)** list all that apply because if their name is not listed we cannot see the patient**.:**

____

Emergency Contact:

Does the following information apply to any siblings? ___ If so, please list:

Name of Patient: ____ DOB: _______________

Name of Patient: ____ DOB: _______________

Name of Patient: ____ DOB: _______________

Name of nearest relative not living with you: ______________________________________

Relationship: ___________________________

Home #: ____________________ Cell #: ________________________ Work: ____________x______

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. 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 Legal Guardian*: _______________________________________ **Date:** _______________

***If other then the patients parents proper documentation shall be requested.**

HIPAA:

See Notice of Privacy Practices

Name of Patient: _____________________________________ **DOB**: ____________

I agree that I have received a copy of the Notice of Privacy Practices for Young & Polite Children's Dentistry.

Signature of Legal Guardian*: _______________________________________ **Date:** _______________

(For Office Use: We were unable to obtain a written acknowledgement of receipt Notice of Privacy Practices because: ____.

Prepared by: _________________________ Signature: ______________________ Date: _______________)

Thank you for choosing Young & Polite Children's Dentistry for your child's new dental home.

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