



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:

Table with 8 columns and 10 rows listing medical conditions and Y/N response options.

Highlighted areas will require a medical clearance

Other: _____

Please explain any of the above circled conditions: _____

7215 Lebanon Rd. Ste F. Mint Hill, NC 28227
704.587.7336(p) 704.587.7579 (f)
www.youngandpolite.com youngandpoliteminthill@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 hereby 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:** _____

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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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