

Southpark Pediatric Dentistry

2700 Coltsgate Rd. • Suite 204 • Charlotte, NC 28211 • Telephone: (704) 749-5700 • FAX: (704) 749-5701

Patient Demographics

First Name: _____ Last Name: _____ Middle Initial _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip _____
Code: _____
Home Phone: _____
Birth Date: _____ Age: _____ MEDICAID ID: _____
Sex (circle) MALE or FEMALE
Referral: _____

PRIMARY RESPONSIBLE PARTY:

First Name: _____ Last Name: _____ Middle Initial _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____
Cell Phone: _____ Email: _____
Relationship to Patient: _____
Birth Date: _____ Age: _____ Soc. Sec: _____
Sex (circle) MALE or FEMALE

Health History

- Yes No Is your child in good health? Date of last physical exam _____
 Yes No Has your child ever had a health problem? _____
 Yes No Has your child ever been hospitalized? Please give reason and dates _____
 Yes No Is your child allergic to anything? _____
 Yes No Is your child currently taking any medications? Please give medication, dose and reason _____
 Yes No Were there any problems at birth? _____

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

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Bleeding/transfusions | <input type="checkbox"/> Asthma/breathing | <input type="checkbox"/> Blood dyscrasias |
| <input type="checkbox"/> Liver/GI disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental delays |
| <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Physical delays |
| <input type="checkbox"/> Eyesight | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Personality/social | <input type="checkbox"/> Other problems |
| <input type="checkbox"/> Cancer/tumors | <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Frequent infections | <input type="checkbox"/> Adverse Drug reactions |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Significant injuries | <input type="checkbox"/> Endocrine/growth | <input type="checkbox"/> Autism |

Please elaborate on any items circled: _____

Dental History

Yes No Has your child ever been to the dentist? Date of last xrays (if taken) _____
Name of dentist and date _____

Yes No Has your child experienced any unfavorable reaction from previous dental care? Explain _____

Yes No Does your child suck a finger, thumb or pacifier?

Yes No Does your child have pain with chewing, yawning, or wide opening?

Yes No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

- | | | |
|---------------------------------------|---|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache | <input type="checkbox"/> Sensitive Teeth |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Color of teeth |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw Sounds | <input type="checkbox"/> Other |

Comments: _____

Consent for Dental Treatment

I request and authorize Dr. Johnson to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Johnson to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Johnson will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature _____ Date _____

Acknowledgement of Privacy Practices (See HIPPA at time of check in)

I certify that I have received a copy of Southpark Pediatric Dentistry's Notice of Privacy Practices.

Patient Name: _____

Parent/Guardian Name: _____

Signature: _____ Date: _____