

Welcome to Pediatric Dentistry & Orthodontics office of Charles W. Connor Jr., DDS, MS

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

CHILD'S Last Name _____ First _____ Middle _____ Child's SSN _____ Today's Date _____
Birthdate _____ Age _____ Sex _____ Race _____ School _____
Child's Home Address _____ Zip Code _____
Lives with Both Parents / Mother / Father / Other _____
Brothers _____ Sisters _____ Pets _____
Child's Physician _____ Last Seen _____ Pharmacy _____ Telephone _____

Guardian Information (who child lives with)

Mother Stepmother Guardian

Name _____ Middle Initial _____ Marital Status: Single, Married, Divorced, Widowed, Separated
Address (if different from above) _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Occupation _____ Email Address _____
Driver's License # _____ SS # _____ Mother's DOB _____

Father Stepfather Guardian

Name _____ Middle Initial _____ Marital Status: Single, Married, Divorced, Widowed, Separated
Address (if different from above) _____
Home Phone _____ Work Phone _____ Cell Phone _____
Employer _____ Occupation _____ Email Address _____
Driver's License # _____ DOB _____ SS # _____

Dental Insurance Information (Primary Only)

Insured's Name _____
Relationship _____
Birthdate _____ Soc Sec # _____
Employer _____
Ins Company _____
Ins Co Address _____
ID# _____ Group# _____
Has your child received previous dental care under this plan? Y N

Reason for bringing child to dentist _____

Whom may we thank for referring you _____

PLEASE HAVE MOST RECENT DENTAL INSURANCE CARD

MEDICAL HISTORY

PATIENT'S NAME _____

PHYSICIAN'S NAME _____

DATE OF LAST PHYSICAL EXAM _____

CHILD'S AGE _____

Please be specific by checking (✓) the box that applies to your child. Blank lines are available to use as needed for explanations.

- | | |
|--|---|
| <input type="checkbox"/> Allergic to latex (rubber) _____ | <input type="checkbox"/> Physical handicaps _____ |
| <input type="checkbox"/> Allergic to any foods _____ | <input type="checkbox"/> Mental handicaps _____ |
| <input type="checkbox"/> Allergic to Codeine _____ | <input type="checkbox"/> Congenital birth defects _____ |
| <input type="checkbox"/> Allergic to local anesthetics _____ | <input type="checkbox"/> ADHA _____ |
| <input type="checkbox"/> Allergic to Penicillin _____ | <input type="checkbox"/> ADD _____ |
| <input type="checkbox"/> Allergic to any other Antibiotics? _____ | <input type="checkbox"/> Rheumatic Fever _____ |
| <input type="checkbox"/> Allergic to Barbituates, sedatives, or sleeping pills _____ | <input type="checkbox"/> Scarlet Fever _____ |
| <input type="checkbox"/> Allergic to Aspirin _____ | <input type="checkbox"/> Skin Rash _____ |
| <input type="checkbox"/> Allergic to Iodine _____ | <input type="checkbox"/> Immune System Disorders (AIDS, HIV, ARC) _____ |
| <input type="checkbox"/> Other? _____ | <input type="checkbox"/> Sinus problems _____ |
| <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Thyroid disorders _____ |
| <input type="checkbox"/> Heart problems _____ | <input type="checkbox"/> Eye disorders _____ |
| <input type="checkbox"/> Mitral valve prolapse _____ | <input type="checkbox"/> Contact lenses _____ |
| <input type="checkbox"/> Heart disease _____ | <input type="checkbox"/> Tonsil or Adenoid problems _____ |
| <input type="checkbox"/> Radiation treatment _____ | <input type="checkbox"/> Speech disorders _____ |
| <input type="checkbox"/> Excessive bleeding _____ | <input type="checkbox"/> Hearing problems _____ |
| <input type="checkbox"/> Anemia or blood problems _____ | <input type="checkbox"/> Endocrine problems _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Ulcer or Colitis _____ |
| <input type="checkbox"/> Seasonal Allergies _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Epilepsy _____ |
| <input type="checkbox"/> Kidney problems _____ | <input type="checkbox"/> Lung or breathing problems _____ |
| <input type="checkbox"/> Liver problems or Hepatitis _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Extreme nervousness _____ |
| <input type="checkbox"/> Psychiatric (mental) problems _____ | <input type="checkbox"/> Ever taken Fen-Phen/Redux _____ |
| <input type="checkbox"/> Emotional problems _____ | |

Please list any medications (including dosages and frequency) your child takes _____

Please list any drugs that have adverse reactions in your child. _____

List any other information that you feel might be of value to us in treating your child. _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or child's) health. It is my responsibility to inform the dental office of any changes in medical status.

DENTAL HISTORY

Please be specific by checking (✓) the box that applies to your child. Blank lines are available to use as needed for explanations.

CHIEF COMPLAINT _____

PREVIOUS DENTIST _____ PHONE # _____ DATE OF LAST DENTAL EXAM _____

ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE YES NO EXPLAIN _____

- | | |
|--|--|
| <input type="checkbox"/> Tooth Pain _____ | <input type="checkbox"/> Orthodontic treatment _____ |
| <input type="checkbox"/> Traumatic injury to mouth or teeth _____ | <input type="checkbox"/> Mouth breathing _____ |
| <input type="checkbox"/> Teeth sensitivity _____ | <input type="checkbox"/> Oral habits, thumbsucking, fingernail biting, _____ |
| <input type="checkbox"/> Bleeding gums _____ | <input type="checkbox"/> cheek biting, etc. _____ |
| <input type="checkbox"/> Food impaction _____ | <input type="checkbox"/> Frequency of brushing _____ |
| <input type="checkbox"/> Clenching or grinding _____ | <input type="checkbox"/> Frequency of dental flossing _____ |
| <input type="checkbox"/> Swelling or lumps in mouth _____ | <input type="checkbox"/> Fluoride supplements _____ |
| <input type="checkbox"/> Frequent fever blisters or cold sores _____ | <input type="checkbox"/> Topical Fluoride Treatment _____ |
| <input type="checkbox"/> Pain around ear _____ | <input type="checkbox"/> Between meal snacks _____ |
| <input type="checkbox"/> Bad breath _____ | <input type="checkbox"/> Well Balanced Diet _____ |
| <input type="checkbox"/> Complications from extractions _____ | |

Is there any other information about your child's teeth or smile that might be of value to us? _____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____

DATE _____

Please tell us how you heard about our office

Phonebooks: _____

Yellow Pages.Com _____

Newspaper: _____

Office Sign: _____

Website: _____

Daycare/School Program: _____

Employee Referral: _____

Family Referral: _____

Friend Referral: _____

Pediatrician Referral: Dr. _____ City _____

Dentist Referral: Dr. _____ City _____

Insurance Company (name of insurance): _____

Flyers: _____

*Note: This Document Contains Different Authorizations. Please Read Carefully, Sign and Date Each.

Notice of Privacy Practices Acknowledgement

Pediatric Dentistry and Orthodontics
1146 North New Hope Road
Gastonia, NC 28054

Acknowledgement of Hippa Policy

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that his organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Consent to Release Pictures of Child/Children for Marketing or Educational Purposes.

I consent to allow my child/children's pictures to be displayed on our website. The pictures also may be displayed in our office as part of advertising services. We may use photos of our patients in our local newspaper or for training and teaching purposes.

Parent or Guardian: _____

Date: _____

_____ Refusal of consent for these purposes listed above.

Authorization to Release Health Information or Consent for Treatment

Appointment of Personal Representative ie. grandparent, aunt, sibling, stepparent. *This person can bring child in for appointments.

1)	_____	_____	_____
	Name	Relationship	Date
2)	_____	_____	_____
	Name	Relationship	Date
3)	_____	_____	_____
	Name	Relationship	Date

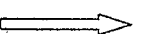
Signed _____
Signature of Parent _____ Date _____

Authorization for Emails or Phone Calls

_____ Emails _____ Phone Calls _____ Voicemail

_____ Leave Message with Next of Kin

_____ Signature of Parent _____ Date _____

Over 

Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

___ An emergency existed & a signature was not possible at the time.

___ The Individual refused to sign.

___ A copy was mailed with a request for a signature by return mail.

___ Unable to communicate with the patient for the following reason:

___ Other: _____

Date: _____

Employee Name: _____

Reason: _____
