Julie C. Spivey DMD
407 N NC 16 Business Highway
Denver, NC 28037
Phone: 704-966-1919 Fax: 704-919-5751
www.lknpediatricdentistry.com

Patient's Name _____ Preferred Name _____

Age ____ Date of Birth _____ Patient's Social Security Number _____

Sex: M F

Home Address _____

Phone (home) _____ Parent or Guardian Email Address _____

Have we previously seen other family members? __ Yes __ No

If Yes, please provide names: _____

Please list your child's hobbies/interests: _____

Do parents live together? __ Yes __ No If no, with whom does child live? _____

Who has legal custody of the patient? _____

PLEASE LIST FULL NAMES OF ALL FAMILY MEMBERS BEING SEEN AS PATIENTS FOR WHOM THIS INFO APPLIES:

_____

_____

_____

_____

****If siblings have different parent/guardian or insurance information, please complete separate forms for each individual patient.**

PARENT OR GUARDIAN INFORMATION ___Mother ___ Stepmother ___ Guardian

Name _____ DOB _____ Occupation _____

Home Address _____

Employer _____ SS # _____ Work Phone _____ Cell _____

P**ARENT OR GUARDIAN INFORMATION** ___Father ___ Stepfather ___ Guardian

Name _____ DOB _____ Occupation _____

Home Address _____

Employer _____ SS # _____ Work Phone _____ Cell _____

PRIMARY DENTAL INSURANCE

Subscriber's Name _____ Relationship to Patient _____

Birthdate _____ Social Security # _____

Employer _____ Insurance Co. _____

Group # _____ Member ID _____

Insurance Co. Phone # _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

LKNPD Medical History

Patient's Name: _____ DOB: _____

Child's Physician:_____

Physician's Phone #: (_____)_____ Date of last visit: _____

Physician's Address: _____
Street City State Zip

Is the child currently under the care of a physician? □ Yes □ No

If yes, please explain:_____

Please describe the child's current physical health: □ Good □ Fair □ Poor

Are Immunizations Current? □ Yes □ No

Please list all medications that the child is currently taking:_____

Please list all medications/foods/other that cause the child allergic reactions: _____

Has the child been diagnosed with or treated for any of the following:

Y N Abnormal Bleeding
Y N AIDS/HIV+
Y N Anemia
Y N Any Hospital Stays/Surgeries
Y N Asthma
Y N Autism Spectrum
Y N Blood Transfusion
Y N Cancer
Y N Cerebral Palsy
Y N Chromosomal Abnormalities
Y N Cleft Palate / Lip
Y N Diabetes
Y N Epilepsy / Seizures
Y N Handicaps / Disabilities
Y N Hearing / Speech
Y N Heart Disease
Y N Heart Murmur
Y N Hemophilia Type ____
Y N Hepatitis Type ____
Y N High / Low Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Rheumatic Fever
Y N Sickle Cell Anemia
Y N Tuberculosis (TB)

Please provide explanation for any "Yes" answers above and any other medical issues the child has/had: _____
_____

Does the child require pre-medication for dental appointments? □ Yes □ No Explain: _____

Do you consider your child to be: □ Progressing normally in the learning process □ Slow in the learning process

Dental History

What is the ***primary*** reason for today's visit? _____

Is your child currently having problems with any of the following?

□ Cavities □ Toothache □ Sensitive Teeth □ Trauma
□ Gum Infection □ Color of Teeth □ Tooth Alignment □ Other _____

Has the child experienced problems with previous dental work? □ Yes □ No Explain: _____

Is the child's home water supply fluoridated (city/county water)? □ Yes □ No

Does the child brush his/her teeth daily? □ Yes □ No # of times per day: ___ Using fluoride toothpaste? □ Yes □ No

Do you give the child any other form of fluoride? □ Yes □ No If yes, what? _____

Does the child floss his/her teeth daily? □ Yes □ No

Was your child bottle/breast-fed? □ Yes □ No If yes, what age was it completely stopped? _____

Does your child suck a finger / thumb / pacifier / or exhibit any other habits? _____

Previous/Present (circle) Dentist: _____ Date of last Visit: _____

What did you like most about any dentist you have seen?_____

Least?_____

Signature _____ Date _____

Relationship to Child_____

Reservation and Cancellation Policy

We strive to provide high quality dental care in the most efficient manner possible for your children. We value your time and reserve a place for your child to see the hygienist and doctor. Your reservation helps us ensure we utilize your time most effectively and ensures that other patients receive the same quality care that you receive. We ask that you review our reservation and cancellation policy and acknowledge this policy with your signature below.

- With your permission, the practice will communicate reservation reminders via text messaging, email, and/or telephone calls.
- We ask that all new patients arrive at least fifteen (15) minutes prior to your reservation time in order to allow for completion of necessary new patient forms.
- We ask that reservation cancellations be made at least 24 hours ahead of the scheduled reservation time.
- The practice understands that emergencies can sometimes arise. Therefore, we will work with you to reschedule your reservation if you must cancel less than 24 hours prior.
- If two reservations are missed without notice, you will be placed on a short-call list and may only be scheduled on short notice if an appointment becomes available. If a third appointment is missed without notice, you will be dismissed from the practice. This decision may be appealed by speaking with our office manager.
- A fee of $35 will be charged for appointments missed without 24 hours' notice.
- The practice reserves the right to cancel your reservation if you are more than ten minutes late for any service.
- The practice reserves the right to modify this policy at any time in the future.

_____ _____

Responsible Party Signature Date

_____

Relationship to Patient(s)

Financial Policy

Please take a moment to review this policy, and acknowledge it with your signature.

- Payment for dental care is expected at the time of service.
- We will strive to verify your insurance benefits prior to treatment. However, your insurance carrier only provides us an estimate of benefits. Any remaining balance becomes your financial responsibility. Any payment not received from your insurance company after 60 days from the treatment date will be due in full from you. Thereafter, you will need to seek reimbursement directly from your insurance company.
- As a courtesy to insured patients, we are happy to help file dental claims on your behalf. However, please remember that **your dental insurance policy is a contract between you, your employer, and the insurance company**. Although we agree to charge reduced fees to you based on your insurance fee schedule, we are not a party to your insurance contract.
- Law requires that this practice collect your copay for dental care received.
- We accept cash or credit card: Visa, MasterCard, American Express, and Discover.
- Account balances greater than 90 days are subject to being forwarded to a collection agency.
- The practice reserves the right to modify this policy at any time in the future.

_____ _____

Responsible Party Signature Date

_____

Relationship to Patient

Photo/Video Consent Form

I, _____, give consent for Lake Norman Pediatric Dentistry to obtain and
Parent/Guardian Name

use photos of my child(ren) _____
Patient Name(s)

for marketing and/or social media purposes on the following media sources:

--Lake Norman Pediatric Dentistry's official Facebook Business page. (https://www.facebook.com/lknpediatricdentistry/)

--Lake Norman Pediatric Dentistry's official Instagram page. (@lknpedatricdentistry)

--www.lknpediatricdentistry.com

I ___ would or ___ would not like to be "tagged" in this photo. If you would like to be tagged, please include your Facebook name and/or Instagram handle below.

Facebook: _____

Instagram: _____

I understand this photo will include identifiable features of my child but WILL NOT include any protected health information or personal information, other than my personal "tag" if I wish.

_____ _____
Parent/Guardian Signature Today's Date

_____
Relationship to Patient

Lake Norman Pediatric Dentistry
Authorization for Release of Information – Compound Release

Please list the names and birth dates of all children you make health care decisions for at our office:

Patient:_____ DOB: _____
Patient:_____ DOB: _____
Patient:_____ DOB: _____
Patient:_____ DOB: _____
Patient:_____ DOB: _____
Patient:_____ DOB: _____

Lake Norman Pediatric Dentistry is authorized to release PHI about the above named patients in the following manner and/or to selected persons.

CHECK EACH PERSON/ENTITY APPROVED TO RECEIVE INFORMATION.	CHECK TYPE OF INFORMATION THAT CAN BE GIVEN TO PERSON/ENTITY ON THE LEFT IN THE SAME SECTION.
☐ Voice Mail	☐ Appointment Reminders
☐ Other person(s)(provide name(s) and phone number(s)):	☐ Financial ☐ Treatment ☐ May bring patient(s) to appointments
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Financial ☐ Treatment ☐ Appointment reminders ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____

☐ For **email and/or text communication** I understand that if information is *not* sent in an encrypted (secure) manner, there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

- I have the right to revoke this authorization at any time by contacting this office.

- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Signature of Patient or Guardian: _____ Date: _____

Relationship to Patient: _____(attach necessary documentation)

☐ Revoked by patient or personal representative on _____.
DATE

How revoked: ♦ orally (in person or via phone) ♦ in writing (place copy in patient's file)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgment****

I, _____, have been offered a copy of this office's Notice of Privacy Practices.

_____

Please Print Name

_____

Signature

_____

Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)