SOUTH GASTON
PEDIATRIC DENTISTRY

NEW PATIENT REGISTRATION

_____ _____ _____ _____ _____
Patient's First Name MI Patient's Last Name Suffix Birthdate mm/dd/yyyy

Prefers to be Called: _____ Age: _____ Gender: □ Male □ Female
Place of Birth: _____ Child's Home Phone #: _____
Street Address: _____ City: _____ State: _____
Zip Code: _____ School/Daycare: _____ Grade: _____
Brothers (names and ages): _____
Sisters (names and ages):_____
Favorite hobbies and interests: _____

Tell Us About Yourself:

Parent/Guardian 1 Full Name: _____ Prefers to be Called:_____
First, MI, Last Suffix (Jr, Sr, I, II, III, Dr)
Relationship to Patient: □ Mother □Father □ Grandparent □Other
Marital Status: _____ Date of Birth: _____ Social Security Number:_____
Street Address:_____
Street, City, State, and Zip if Different from Patient Apt. #t
Home Phone:_____ Cell Phone: _____ Work Phone:_____
Email: _____ Occupation:_____
Employer: _____
Is this person legally responsible for the healthcare decisions of the patient? □ No □Yes

Parent/Guardian 1 Full Name: _____ Prefers to be Called:_____
First, MI, Last Suffix (Jr, Sr, I, II, III, Dr)
Relationship to Patient: □ Mother □Father □ Grandparent □Other
Marital Status: _____ Date of Birth: _____ Social Security Number:_____

Street Address:_____
Street, City, State, and Zip if Different from Patient Apt. #t
Home Phone:_____ Cell Phone: _____ Work Phone:_____
Email: _____ Occupation:_____
Employer: _____
Is this person legally responsible for the healthcare decisions of the patient? □ No □Yes

3340 Robinwood Rd Ste. 140, Gastonia, NC 28054
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EMERGENCY CONTACT AND INSURANCE INFORMATION

Patient's Name:_____ Date of Birth:_____
Patient's First Name MI Patient's Last Name Suffix mm/dd/yyyy

Emergency Contact Information:

Emergency Contact (Friend or Relative NOT Living with You):_____
Relationship to the Patient: _____
Street Address: _____ Apt. # _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Coverage #1:
Subscriber's First Name: _____ Subscriber's Last Name: _____
Date of Birth: _____ Insured's Employer: _____
Patient's Relationship to Subscriber: □ Self □Child □Handicapped Dependent □Spouse □Dependent
Name of Insurance Carrier: _____ Subscriber ID #: _____
Social Security Number if Different from Subscriber ID: _____
Group Name:_____ Group Number: _____
Carrier Phone: _____
Carrier Address:_____

Insurance Coverage #2:
Subscriber's First Name: _____ Subscriber's Last Name: _____
Date of Birth: _____ Insured's Employer: _____
Patient's Relationship to Subscriber: □ Self □Child □Handicapped Dependent □Spouse □Dependent
Name of Insurance Carrier: _____ Subscriber ID #: _____
Social Security Number if Different from Subscriber ID: _____
Group Name:_____ Group Number: _____
Carrier Phone: _____
Carrier Address:_____

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PEDIATRIC DENTISTRY

MEDICAL HISTORY

Patient's First Name	MI	Patient's Last Name	Suffix	Birthdate mm/dd/yyyy
_____	_____	_____	_____	_____

Medications
List all medications your child is currently taking. Include dosage and frequency if known.
_____

Allergies
Please list any known allergies:
_____

Who is your child's Pediatrician/Physician? _____

Pediatrician/Physician Address and Phone: _____

Medical Condition/Problems
Does your child have any of the following medical conditions and/or been treated for them?

Y	N		Y	N		Y	N	
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Cerebral Palsy
☐	☐	Seizures	☐	☐	Blood Disorder	☐	☐	Premature Birth
☐	☐	Epilepsy	☐	☐	Prolonged Bleeding	☐	☐	Endocrine/ Growth Problems
☐	☐	Fainting	☐	☐	Blood Transfusion	☐	☐	Hormonal Problems
☐	☐	Convulsions	☐	☐	High Blood Pressure	☐	☐	Behavior Problems
☐	☐	Diabetes	☐	☐	Low Blood Pressure	☐	☐	Learning Problems
☐	☐	Kidney Problems	☐	☐	Rheumatic Fever	☐	☐	Speech Problems
☐	☐	Bladder Problems	☐	☐	Rheumatic Heart Disease	☐	☐	Hearing Problems
☐	☐	Liver Problems	☐	☐	Tuberculosis	☐	☐	Vision Problems
☐	☐	Jaundice	☐	☐	Pneumonia	☐	☐	Previous Surgery/ Hospitalizations
☐	☐	Hepatitis	☐	☐	HIV/AIDS	☐	☐	Pending Surgery
☐	☐	Cancer	☐	☐	Autism Spectrum Disorder	☐	☐	Other Please Describe: _____
☐	☐	Heart Murmur						
☐	☐	Congenital Heart Diesease						

Parents Signature X_____ Date: _____

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DENTAL HISTORY

Patient's First Name	MI	Patient's Last Name	Suffix	Birthdate mm/dd/yyyy
_____	_____	_____	_____	_____

□ 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 had any unfavorable reactions to dental treatment?
If so, please explain: _____

□ Yes □ No Does your child have pain?
If so, please explain: _____

Any Oral Habits?

□ Yes □ No Thumb Sucking □ Yes □ No Mouth Breathing □ Yes □ No Grinding of Teeth
□ Yes □ No Finger Sucking □ Yes □ No Pacifier □ Yes □ No Nail Biting
□ Yes □ No Lip sucking

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

□ Yes □ No Cavities □ Yes □ No Toothache □ Yes □ No Sensitive Teeth
□ Yes □ No Trauma □ Yes □ No Gum Infections □ Yes □ No Color of Teeth
□ Yes □ No Orthodontics □ Yes □ No Jaw Sounds □ Yes □ No Other
□ Yes □ No Other Please describe:_____

CONSENT FOR DENTAL TREATMENT

I authorize the rendering of diagnostic and treatment procedures, including but not limited to fluoride, local anesthesia, and radiographs, by the doctors and dental staff of Belmont Pediatric Dentistry, in their professional judgment may be deemed necessary or beneficial.
However, prior to rendering any definitive treatment the proposed treatment plan will be presented and/or discussed with the parent or guardian.

I further understand this consent will remain in effect until such time I choose to terminate it.

Parent's Signature: _____ Date _____

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Acknowledgement of Privacy Practices

_____	_____	_____
Patient First Name	Patient Last Name	Birthday mm/dd/yyyy

I certify I have received a copy of South Gaston Pediatric Dentistry's Notice of Privacy Practices

Signature of Parent/Guardian_____ Date _____

Printed name of Parent/Guardian: _____

I give full permission for the below listed, to have complete access to patient listed above. This includes, but is not limited to, chart details, x-rays, and dental restoration needed. I also give full authority to make any decisions necessary for any treatment planned in relation to the patient's dental needs from South Gaston Pediatric Dentistry.

Name/Relationship to patient: _____
Name/Relationship to patient: _____

Signature of Parent/Guardian_____ Date _____
Printed name of Parent/Guardian: _____

Staff Will Complete This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain a written Acknowledgement of Receipt of our Notice of Privacy Practices, but it could not be obtained for the following reason(s):

- □ Parent/Patient/Guardian refused to sign
- □ Emergency situation kept us from obtaining signature
- □ Language barrier kept us from obtaining signature
- □ Other:

Signature of Company Representative: _____ Date _____

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FINANCIAL AND INSURANCE INFORMATION

_____	_____	_____
Patient's First Name	Patient's Last Name	Birth Date mm/dd/yyyy

Payment Policy

Payment is due in full at the time dental treatment is provided. For your convenience, we offer the following methods of payment: Cash, MasterCard, Visa, Discover and Care Credit (see Financing Program below.)

Dental Benefits

We are dedicated to providing all our patients with the finest treatment available. We base our treatment recommendations on what will be best for your child, not what your insurance company may or may not pay. Please note the following in regards to your dental insurance coverage:

1. We must emphasize, as a health care provider, our relationship is with you and your child, not your dental insurance company. Your dental insurance is a contract between your employer and the insurance company. Most plans routinely pay between 50% -80% of the fee the insurance company sets, which are not the fees typically set by dental practices.
2. Any amount determined not covered by your insurance company is payable at the time services are rendered; these fees may include deductibles, co-payments, or certain procedures not included in your insurance policy. Keep in mind, some of the services we may recommend for your child will not be covered by your specific dental policy. It is your responsibility to know your dental benefits. FOR ALL NON -COVERED SERVICES, WE REQUIRE YOUR CO-PAY OF THE TOTAL TREATMENT PLAN TO BE PAID ON THE DATE OF SERVICE. Any overpayment will be refunded to you upon receipt of claim payment.
3. OUR OFFICE DOES NOT DETERMINE YOUR DENTAL BENEFITS. Your employer chooses a particular policy and if you are not pleased with its specific coverage, this should be brought to your supervisor's attention. Only your employer can adjust or change benefits.

If you do not have dental coverage, we may be able to assist you in obtaining dental coverage. If you are unable to obtain dental coverage, we are happy to offer a self pay discount.

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Financing Program

To help provide cost-effective care to our patients, we work with CARE CREDIT, a healthcare lender, to offer financing programs for dental treatment. Please feel free to inquire about this program.

We do our best to maximize the insurance benefits you are eligible to receive and we appreciate your prompt settlement of any charges incurred during your child's treatment process. If there is an unpaid balance after 30 days from the date of service, you will receive the first statement. If the account is 60 past due from the date of service, a late fee of $25.00 will be applied. If the account is 90 days late from the date of service, the account will be sent tf collections along with a final late fee applied in the amount of $25.00.

We strive to provide you and your child concern, respect, and care to makes our office a comfortable and pleasant place to visit. In return, we kindly ask for your consideration of our time. We request at least 24 hours notice to cancel or reschedule any appointment. Failure to comply with this policy may result in a fee assessment.

We look forward to many years of close association with you as we work to optimize your child's oral health. I have read, understood and had all questions answered about the financial policies at South Gaston Pediatric Dentistry.

Financial Obligation

X_____

Date _____

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LATE AND BROKEN APPOINTMENT POLICY

Patient's First Name	MI	Patient's Last Name	Suffix	Birthdate mm/dd/yyyy
_____	_____	_____	_____	_____

At South Gaston Pediatric Dentistry, we aim to give our patients the best, and our quality treatment is a result of quality time spent with your patients and their families. Help us make our time together optimal by adhering the following guidelines:

1. **Confirming your child's appointment.** Please respond to our confirmation call by text, phone call or email within 24 hours of your child's appointment. Unconfirmed appointments are subject to cancellation, and any unconfirmed appointment will be treated as a broken appointment (see #3 below).

2. **Arrive on time.** Arrivals exceeding 10 minutes are subject to rescheduling.

3. **Broken appointments.** Not showing up for your confirmed appointment will result in a $25 fee for hygiene appointment and $75 fee for an operative appointment per child.

Parent/Guardian Signature: _____ Date: _____

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PHOTO CONSENT FOR MARKETING / SOCIAL MEDIA

_____	_____	_____
Patient First Name	Patient Last Name	Birthday mm/dd/yyyy

I, (print name) _____, authorize **Cooke and Mvula, PLLC** to
Parent/legal guardian
take and use: photographs and/or digital images of my child for use on social media websites, personal website and/or any other marketing purposes. I agree my child's name and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me. All negatives, prints digital reproductions shall be the property of all the above released practice.

X_____ Date:_____
Parent/legal guardian signature

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