E-mail address: ____

American Dental Association
www.ada.org

Child Health/Dental History Form

Patient's Name (LAST, FIRST, INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS, CITY, STATE, ZIP CODE)		
Phone (Home, Work)	Sex M ❑ F ❑	

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?

If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other____________
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician ____ Phone ____________________

Child's History

Yes No

1. Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? .... 1. ❑ ❑
   If yes, please list: ____
2. Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: ____________ 2. ❑ ❑
3. Is the child allergic to anything else, such as certain foods? If yes, please explain: ____________ 3. ❑ ❑
4. How would you describe the child's eating habits? ____
5. Has the child ever had a serious illness? If yes, when: ____________ Please describe: ____________ 5. ❑ ❑
6. Has the child ever been hospitalized? .... 6. ❑ ❑
7. Does the child have a history of any other illnesses? If yes, please list: ____________ 7. ❑ ❑
8. Has the child ever received a general anesthetic? .... 8. ❑ ❑
9. Does the child have any inherited problems? .... 9. ❑ ❑
10. Does the child have any speech difficulties? .... 10. ❑ ❑
11. Has the child ever had a blood transfusion? .... 11. ❑ ❑
12. Is the child physically, mentally, or emotionally impaired? .... 12. ❑ ❑
13. Does the child experience excessive bleeding when cut? .... 13. ❑ ❑
14. Is the child currently being treated for any illnesses? .... 14. ❑ ❑
15. Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: ____________ 15. ❑ ❑
16. Has the child had any problem with dental treatment in the past? .... 16. ❑ ❑
17. Has the child ever had dental radiographs (x-rays) exposed? .... 17. ❑ ❑
18. Has the child ever suffered any injuries to the mouth, head or teeth? .... 18. ❑ ❑
19. Has the child had any problems with the eruption or shedding of teeth? .... 19. ❑ ❑
20. Has the child had any orthodontic treatment? .... 20. ❑ ❑
21. **What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water
22. **Does the child take fluoride supplements?** .... 22. ❑ ❑
23. **Is fluoride toothpaste used?** .... 23. ❑ ❑
24. How many times are the child's teeth brushed per day? __________ When are the teeth brushed? ____________ 24. ❑ ❑
25. Does the child suck his/her thumb, fingers or pacifier? .... 25. ❑ ❑
26. At what age did the child stop bottle feeding? Age __________ Breast feeding? Age __________
27. Does child participate in active recreational activities? .... 27. ❑ ❑

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.

I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature ____ Date ____________________

For completion by dentist

Comments ____

____

____

____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by ____________________

Date ____

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Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

STANLY COUNTY HEALTH DEPARTMENT
DENTAL CLINIC
PEDIATRIC PATIENT POLICY

1. I understand that I am allowed to be present for my child's initial exam appointment. If your child is school aged, we recommend parents waiting in the waiting room, however, if your child becomes uncooperative you will be required to accompany your child.

2. I understand that Stanly County Health Department's treatment for children includes efforts to help them understand the treatment in terms appropriate for their age. The clinic will provide an environment that is likely to help children learn to cooperate during treatment. To accomplish this, the patient's behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

3. I understand that should my child become uncooperative during dental procedures with the movement of the head, arms, and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) to hold the patient's hands, stabilize the head and/or control leg movements. A mouth prop may be necessary to maintain mouth opening.

4. The usual and most frequently occurring risks or complications occurring include but are not limited to, the possibility of pain or discomfort during or following treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint (TMJ) disorder, temporary or permanent numbness and allergic reactions.

5. I (parent/guardian) give permission for any treatment deemed necessary by the dentist, which may include cleanings, fluoride treatments, x-rays, sealants, fillings, crowns, and/ or pulp therapy.

I have read and understood the above policy and agree to abide by the presented information.

Patient Name:____

Signature of Parent or Guardian: ___________________________________

Date: ________________________

Stanly County Health Department
Dental Clinic

1000 North First Street, Suite 3
Albemarle, N.C. 28001
704-986-3845

CONSENT FOR NITROUS OXIDE

I, ____, as a legally
(Parent/Legal Guardian/Authorized Individual)

responsible person (as the legally responsible parent/guardian) of:

(Patient's Name) ______________________________________

give my consent for the use of Nitrous Oxide/Oxygen (laughing gas, happy air) as deemed appropriate by the Doctor at Stanly County Dental Clinic to help control anxiety for the child named above during dental treatment.

I have been informed that the Nitrous Oxide may make my child feel "tingly" or "floaty" and that the Nitrous Oxide will be completely dissipated from the patient's system after 2 to 3 minutes of breathing room air. I also understand that, while it rarely occurs, nausea is a possible adverse affect of the Nitrous Oxide.

I understand that I, or an authorized individual, must remain in the office during my child's entire procedure.

I have read this consent and understand, to my satisfaction, the procedures to be performed and the risks involved.

Legally responsible person (parent/guardian)________________________________
(Signature)

____________________________________ ____________________
(Print Name) (Date)

Witness: ____

STANLY COUNTY HEALTH DEPARTMENT
DENTAL CLINIC
CANCELLATION /BROKEN APPOINTMENT POLICY

We have adopted the following policy due to our large patient population and our commitment to efficient and quality dental treatment for our patients. This policy will enable Stanly County Dental Clinic patients to be seen as close to their scheduled appointment time as possible, and prevent them from waiting due to another patient's tardiness.

A 24 hour notice is required for all cancellations other than sudden patient illness; otherwise, the appointment will be considered broken. All cancellation appointments will be recorded in the patient's chart.

If a patient is more than 15 minutes late for a scheduled appointment time, it will be considered a broken appointment.

All broken appointments will be recorded in the patient's chart. After 2 broken appointments within a 12 month period, the patient will not be eligible for treatment at the Stanly County Dental Clinic for one year. These patients will only be seen for emergency treatment as defined by the provider during the waiting period. A new exam will be required prior to any treatment completion.

I have read the above Cancellation/Broken Appointment Policy and agree to abide by these conditions.

Patient's Name: ____

Patient/Guardian's Signature: ______________________________

Date: _____________

STANLY COUNTY DENTAL CLINIC
PATIENT INFORMATION FORM

Patient Name: ____

Has patient ever been diagnosed with a Heart Murmur? Y / N **When:** ____________________

Name of Physician: __________________________ **Phone:** ____________________

Pharmacy Name: ____

Parent Email: ____

Alternate Contact Person: ______________________ **Alternate Phone:** ________________

Relationship to Patient: ____

School Patient Attends (please indicate if home schooled): ______________________

Race:
- □ American Indian
- □ Alaskan American
- □ Asian
- □ Black or African American
- □ Native Hawaiian or Other Pacific Islander
- □ White
- □ Other
- □ Hispanic/Latino
- □ Unspecified or Declined to Specify

Ethnicity:
- □ Hispanic or Latino
- □ Non-Hispanic or Latino
- □ Declined to Specify

Dental Insurance Information
Please submit a copy of your insurance card.

Insurance Company: ______________________________

Primary Insured Name: ____________________________ **Employer:** ____________________

Insured Social Security Number: ____________________ **Insured D/O/B:** ________________

Group Number: ____________________________ **Subscriber ID:** ________________

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named dental entity.

____
Signature of Parent/Guardian

Last Name First Name MI

Patient record#: ____________________

Date of Birth: ____/_____/__________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I am acknowledging that:

I am either the patient or the patient's personal representative;
I have received a copy of the "Notice of Privacy Practices" for ________________ County/District Health Department; and
I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

____ __________
Signature of patient or parent/legal guardian/legally responsible person Date

____
Description of relationship to patient

TO BE COMPLETED BY STAFF

Complete all applicable parts—Please refer to instructions

Part 1. Complete if signature requested but not obtained:
Staff member sought but was unable to obtain an acknowledgment from the patient or the patient's personal representative for the following reason:

D Patient/personal representative refused to sign form

D Other ____

____

Part 2. Complete if patient/personal representative unavailable to sign form on first date of service delivery:
D Form mailed/sent to patient/personal representative on __________________.
Date

Part 3. Complete if either Part 1 or Part 2 completed:

____ __________
Signature of staff member Date

DHHS 3096 E (Revised 01/13
LTAT (Review 1/13)

Stanly County Human Services Agency
1000 North First Street, Suite 3
Albemarle, NC 28001
Phone (704) 982-9171 Fax (704) 982-8354
www.stanlycountync.gov

G. David Jenkins, MPA
Health & Human Services Director

Dolly Huffman Clayton, MSW, LCSW
Social Services Director/Assistant
Health & Human Services Director

STATEMENT FOR PATIENTS: COLLECTION AND USE OF SOCIAL SECURITY NUMBERS BY STANLY COUNTY HEALTH DEPARTMENT

Stanly County Health Department asks all patients to provide social security numbers, so that we have a means to uniquely identify each patient. Provision of your social security number is voluntary. Your social security number will be kept confidential in accordance with state and federal laws that protect the privacy of health information.

Stanly County Health Department is legally authorized to collect and use patient social security numbers for the following purposes:

- Determining whether patients are presumptively eligible for Medicaid (10A NCAC 22K.0102)
- Participating in the local government debt set-off program (G.S. 105A-3)
- The following activities, which require a unique identifier and are imperative to the performance of Stanly County Health Department's legally prescribed duties and responsibilities (G.S. 132-1.10):
  - Uniquely identifying medical records
  - Accessing or billing third-party insurance systems
  - Submission of specimens to the state public health laboratory
  - Newborn screening program
  - Investigation and control of communicable diseases and other public threats
  - North Carolina immunization registry
  - Breast and cervical cancer screening programs
  - Arranging patients' participation in "purchase of care" programs, which help pay for health care
  - Public health surveillance

______________________________ ______________________
Client's Signature Date

______________________________ ______________________
Witness's Signature Date

Stanly County Dental Clinic (704)986-3845

1000 N. First St. , Suite #3

Albemarle, NC 28001-2833

Consent for Internet Communications

I grant my permission to the Stanly County Dental Clninc to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

* ☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.

Name of patient, parent, or guardian completing this form:

* ____________________

Relationship to patient:

* ____________________

Response Date: ____________