Carnaggio & Piper DMD, MS, PA

275 N. Main St. Unit B
Troutman, NC 28166

CHILD REGISTRATION AND HEALTH HISTORY ____/_____/_____ Date

First Name (MI) Last Name Nickname Birth Date Age

Address City State Zip Code

School Address Grade

Mother's Details ☐ Primary Contact Does Mother have legal custody of child? _____

Name Home Phone Cell Phone

Employment Work Phone

Social Security No. Driver's License No./ State Birth Date

Father's Details ☐ Primary Contact Does father have legal custody of child? _____

Name Home Phone Cell Phone

Employment Work Phone

Social Security No. Driver's License No./ State Birth Date

If neither parent has custody of child who is child's guardian? _____

What is the guardian's relationship to the child? _____

Person Financially Responsible (if other than parent) Relationship to Child

Dental Insurance Carrier (if any) Whom may we thank for referring you.

DENTAL HISTORY

Date of last visit to dentist_____/_____/_____ For what service_____

1. Has child complained about dental problems ☐ Yes ☐ No _____
2. Any unhappy dental experiences ☐ Yes ☐ No _____
3. Any injuries to mouth-teeth-head ☐ Yes ☐ No _____
4. Any mouth habits (circle any that apply): thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifer
5. Any unusual speech habits ☐ Yes ☐ No _____
6. Any lost teeth ☐ Yes ☐ No
7. Have missing teeth been replaced ☐ Yes ☐ No
8. Orthodontic appliances ever been worn ☐ Yes ☐ No
9. Does child brush daily ☐ Yes ☐ No
10. Use floss ☐ Yes ☐ No Frequency _____
11. Use disclosing tablets ☐ Yes ☐ No
12. Use fluoride ☐ Yes ☐ No In what form_____ Frequency _____
13. Child's attitude towards dentistry? _____

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HEALTH HISTORY

Child's physician_____ _____ _____
Address **Phone No.**

Date of last physical exam _____/_____/_____ **Results**_____

Is child currently under a physician's care ☐ **Yes** ☐ **No** **Reason**_____

Is child receiving medication or drugs ☐ **Yes** ☐ **No** **List, if any** _____

Is there any excessive bleeding when cut ☐ **Yes** ☐ **No**

Has child ever been hospitalized ☐ **Yes** ☐ **No** **Reason**_____

List any surgery child has ever had _____

Any allergy to penicillin or other drugs (specify)_____

Any other allergies (food-pollen-animals-dust-other)_____

Does child have good physical coordination ☐ **Yes** ☐ **No (specify)**_____

Does child have any emotional problems ☐ **Yes** ☐ **No (specify)**_____

Does child have any history of or difficulty with any of the following:

☐ **Anemia**	☐ **Chronic sinus**	☐ **Hearing**	☐ **Mastoid**	☐ **Rheumatic Fever**
☐ **Asthma**	☐ **Convulsions**	☐ **Heart**	☐ **Measles**	☐ **Thyroid**
☐ **Bladder**	☐ **Diabetes**	☐ **Kidney**	☐ **Mononucleosis**	☐ **Tuberculosis**
☐ **Cerebral Palsy**	☐ **Epilepsy**	☐ **Liver**	☐ **Malignancies**	☐ **Venereal Disease**
☐ **Chicken Pox**	☐ **Fainting**	☐ **Mumps**	☐ **Other** _____	

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of that has not been previously discussed

_____
_____
_____
_____
_____

May we request release of your child's medical records for our reference ☐ **Yes** ☐ **No**

_____ _____/_____/_____

Parent/Guardian Signature **Date**

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NOTICE OF PRIVACY PRACTICES

Your privacy is very important to us. We promise to take every precaution to protect your rights to having your health care information secure. Our formal notice of privacy practices is posted in the waiting area. Please read this while waiting for your visit. You may also request a copy of this notice from the receptionist.

We also need to ask our patients how they wish to be notified about upcoming appointments. Mt. View Family Dentistry may call my home to confirm upcoming appointments and may leave a message on my answering machine if I am not available. ____YES ____NO

I have read the posted notice and/or requested a copy of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at the address above to obtain a current copy of the policy.

PATIENT CONSENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up amount the multiple health care providers who may be involved in that treatment directly and indirectly.
- Contact third party payers such as an insurance company to verify benefits.
- Obtain payment from third party payers such as insurance companies.
- Conduct normal health care operations such as quality assessment and physician certifications.
- Contact me by phone for appointment reminders.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this 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.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME: _____

SIGNATURE: _____ DATE: _____/_____/_____
(Parent/Guardian if patient is a minor)

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FINANCIAL POLICY

Payment for services is due at the time of treatment by one or more of the following:

- Dental Insurance (We accept and file most dental insurances, but we are only an in-network provider for Delta Dental insurance and BCBSNC.
- Cash, debit/credit card or check
- CareCredit (a monthly payment plan which requires prior credit approval through an independent company)

Insurance: Insurance is a contract between you and your insurance company. We are **NOT** a party to this contract. We will verify and file your PRIMARY insurance, as a courtesy to you.

NOTE: ALTHOUGH WE MAY ESTIMATE WHAT YOUR INSURANCE MAY PAY, IT IS THE INSURANCE COMPANY THAT MAKES THE FINAL DETERMINATION OF YOUR ELIGIBILITY. WE DO **NOT** GUARANTEE THE ACCURACT OF ANY ESTIMATE OF BENEFITS RELATING TO THE PATIENT'S PLANNED OR RENDERED TREATMENT. YOU ARE RESPONSIBLE FOR PAYMENT OF ANY PORTION OF THE CHARGES WHICH ARE NOT COVERED BY YOUR INSURANCE. Benefits are payable in accordance with the coverage in effect at the time treatment is actually rendered and are subject to plan maximums, deductibles, co-insurance factors and any other specific plan limitations. It is your full responsibility to understand the terms and conditions of your coverage. You are responsible for paying any deductibles and co-payments at the time treatment is rendered.

We will gladly file your Medicaid, North Carolina Health Choice or your dental insurance at this office. In order to do so, you must be able to present your current insurance card. If you have a co-payment or out of pocket expense, you are required to pay this that the time of service.

Returned Checks: You will be charged a fee (currently $30 plus the bank's fee) for any checks returned to us by your bank. After a returned check, only cash or credit card payments will then be accepting for future services or remaining account balance.

Monthly Statements: If you have a balance on your account for any reason, we will send you a monthly statement. Unless other arrangements are agreed to by us, the balance on your statement is due and payable by the indicated due date and will be considered past due if not paid by such date.

Past Due Accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you may also be assessed a collection fee.

Cancellation Policy: 24-hour notice is required for any cancellations. If you fail to provide a 24-hour notice or you do not show for your scheduled appointment, you will not longer be able to schedule future appointments.

PATIENT NAME: _____

SIGNATURE: _____ DATE:_____/_____/_____
(Parent/Guardian if patient is a minor)