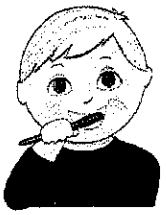
PENDER COUNTY HEALTH DEPARTMENT

MOBILE DENTAL CLINIC

803 S. Walker Street, Burgaw, NC 28425
(910) 471-3250



Dr. Kathy Barnes, DDS

PATIENT INFORMATION

LAST NAME:_____ FIRST NAME:_____ MI:____

MAILING ADDRESS:_____
City State Zip Code

DATE OF BIRTH:_____ MALE__ FEMALE__RACE___SOCIAL SECURTY#:_____

TEACHER:_____ GRADE: ____ AFTER SCHOOL PROGRAM: YES____NO____

PARENT/LEGAL GUARDIAN

LAST NAME:_____ FIRST NAME:_____ MI:____

CELL PHONE #:_____ or DAYTIME PHONE #:_____

EMERGENCY CONTACT:_____ PHONE #:_____

PAYMENT INFORMATION

DOES YOUR CHILD HAVE MEDICAID OR HEALTH CHOICE? YES_____ NO_____

IF YES, PLEASE PROVIDE MEDICAID OR HEALTH CHOICE CARD #:_____

INSURANCE:

DOES YOUR CHILD HAVE DENTAL INSURANCE? YES_____ NO_____

IF YES, PLEASE PROVIDE THE FOLLOWING INFORMATION:

POLICY HOLDER'S NAME:_____ SSN#:_____ Date of Birth_____

INS. CO. NAME & ADDRESS :_____ SUBSCRIBER #:_____

GROUP PLAN #:_____ INSURANCE PHONE #:_____

EMPLOYER:_____ Payer ID#_____

IF POSSIBLE, PLEASE SEND A COPY OF YOUR INSURANCE CARD, FRONT AND BACK. THANK YOU

PRIVATE PAY:

IF YOU DO NOT HAVE INSURANCE AND WANT TO APPLY FOR A DISCOUNT PLEASE PROVIDE THE FOLLOWING INFORMATION:

FAMILY MEMBERS LIVING IN THE HOME: # OF ADULTS:_____ # OF CHILDREN:_____

TOTAL MONTHLY HOUSEHOLD INCOME $_____ EMPLOYER:_____

DO YOU RECEIVE UNEMPLOYMENT? YES_____ NO_____ AMOUNT: $_____

DO YOU RECEIVE DISABILITY? YES_____ NO_____ AMOUNT: $_____

DO YOU HAVE ANY OTHER FORM OF INCOME? YES_____ NO _____ AMOUNT: $_____

If Yes Please Explain:_____

*PLEASE NOTE: PROOF OF INCOME MAY BE REQUESTED. THANK YOU

PATIENT DENTAL AND MEDICAL HISTORY

DENTAL HISTORY

HAS YOUR CHILD EVER BEEN TO THE DENTIST BEFORE? YES_____ NO_____

IF YES, WHEN AND WHERE WAS HIS/HER LAST DENTAL VISIT:_____

WERE X-RAYS TAKEN AT THAT VISIT? YES_____ NO_____

HAS YOUR CHILD EVER HAD A BAD OR SCARY EXPERIENCE AT THE DENTIST? YES_____ NO_____

HOW OFTEN DOES YOUR CHILD BRUSH HIS/HER TEETH: _____

DOES ANYONE HELP YOUR CHILD BRUSH HIS/ HER TEETH? YES_____ NO_____

DOES YOUR CHILD FLOSS HIS/HER TEETH? YES_____ NO_____

HISTORY OF (Check all that apply)

____ BLEEDING GUMS ____ THUMB SUCKING ____ BOTTLE HABITS ____CAVITIES

____ BAD BREATH ____ PAIN IN TEETH ____ SNORING ____ GRINDING TEETH

____ COLD SORES/CANKER SORES

IS YOUR CHILD IN PAIN NOW WITH HIS/HER TEETH? YES_____ NO_____
EXPLAIN:_____

DO YOU HAVE ANY CONCERNS WITH YOUR CHILD'S TEETH? YES_____ NO_____
EXPLAIN:_____

MEDICAL HISTORY (Check all that apply)

_____ ADD/ADHD ____ AIDS/HIV ____ ANEMIA ____ ASTHMA

____ AUTISM ____ BEHAVIORAL PROBLEMS ____ CANCER ____ TB

____ DIABETES ____DEVELOPMENTAL ____ HEMOPHILIA ____TRANSPLANT

____ EPILEPSY/SEIZURES ____ HEPATITIS ____ KIDNEY DISEASE ____ CELIAC (Gluten Allergy)

____ HEARING PROBLEMS ____ RHEUMATIC FEVER ____ PSYCHIATRIC CARE ____Downs Syndrome

____ EYE PROBLEMS ____ GLASSES/CONTACTS ____ HIGH BLOOD PRESSURE____Special Needs

____ HEART CONDITIONS (Please list) _____

PLEASE LIST THE FOLLOWING:

HAS YOUR CHILD EVER EXPERIENCED AN ALLERGIC REATION TO ANYTHING? YES_____ NO_____
EXPLAIN:_____

DOES YOUR CHILD TAKE ANY MEDICATIONS: IF SO, PLEASE LIST:_____

SURGERIES/HOPSITAL STAY:_____

OTHER HEALTH CONDITIONS NOT LISTED:_____

PERMISSION

Each child receives a comprehensive examination, radiographs, a cleaning, fluoride and preventive sealants if needed on their initial visit. I give permission for my child _____ to receive these services provided by Dr. Kathy Barnes without my presence.

After dental treatment is completed on my child I agree that Dr. Kathy Barnes may file claims for dental care with the insurance company or other payer information that I have provided.

Signature of Parent/Legal Guardian: _____ Date: _____

HIPPA PRIVACY POLICY AVAILABLE UPON REQUEST