GREAT NEWS!

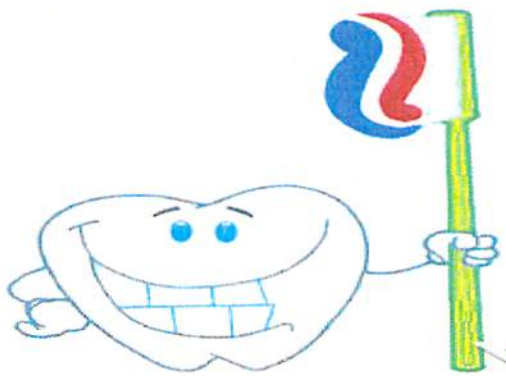
Dear Parent/Legal Guardian:

We are so excited to announce that the Pender County Health Department Mobile Dental Clinic along with Dr. Kathy Barnes DDS and staff will be at your child's school soon!!

The Mobile Dental Clinic provides dental services to children during school and after school hours. If you would like for your child to be seen, please fill out the attached form and return it to your child's teacher as soon as possible. Our dental services are also available for school staff, parents and all members of the community. We will also file insurance for patients if available. We can also check to see if your student qualifies for Medicaid or our Sliding Fee Scale.
If you have any questions please call 910-471-3250.

We look forward to meeting and treating your child!
Sincerely,

Pender County Health Department
Mobile Dental Clinic



****TEACHERS PLEASE PLACE COMPLETED FORMS IN THE NURSE BOX****

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 #:_____

EMAIL_____ 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

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 REACTION 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