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**_____ **SOCIAL SECURITY#:**

TEACHER: _____**GRADE:** _____ **AFTER SCHOOL PROGRAM: YES**_____ **NO**

PARENT/LEGAL GUARDIAN

LAST NAME: _____ **FIRST NAME:** _____ **MI:**

CELL PHONE #:_____ **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**_____

INSURANCE CO. NAME & ADDRESS: _____ **SUBSCRIBER #:**_____

GROUP PLAN #:_____ **INSURANCE PHONE #:**_____

EMPLOYER: _____

****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:

TOTAL NUMBER OF FAMILY MEMBERS LIVING IN THE HOME: ADULTS: _____ **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: _____

YOUR CHILD'S MEDICAL HISTORY (Check all that apply)

_____ADD/ADHD ___ AIDS/HIV ___ ANEMIA ___ CANCER

___AUTISM ___BEHAVIORAL PROBLEMS ____DOWN SYNDROME ___SPECIAL NEEDS

___ CELIAC (Gluten Allergy) ___DEVELOPMENTAL ___HEMOPHILIA ___DIABETES

___EPILEPSY/SEIZURES ___HEPATITIS ___KIDNEY DISEASE ___ ASTHMA

___HEARING PROBLEMS ___ RHEUMATIC FEVER ___PSYCHIATRIC CARE ___TRANSPLANT

___EYE PROBLEMS ___GLASSES/CONTACTS ___HIGH BLOOD PRESSURE ___TB

___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/HOSPITAL STAYS: _____

OTHER HEALTH CONDITIONS NOT LISTED: _____

PERMISSION

Each child receives a comprehensive examination ($83), radiographs ($44), a cleaning ($72), fluoride ($50) and preventive sealants ($55/tooth) if needed on their initial visit. You are responsible for these fees unless you provide Medicaid or Dental Insurance information necessary in order to file a claim. If you do not have any coverage you may provide proof of income to see if you qualify for a discount on the above fees. 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: