Coastal Pediatric Dentistry

ROBERT HARRISON, D.M.D., M.S.D.
700 McCarthy Boulevard, New Bern, NC 28562
252-633-0424 • Fax:252-638-6662
info@coastalpediatricdentistry.com
www.drbobh.com

Patient Name: _____ Nickname: _____ Sex: _____ Date of Birth: _____ Age: _____

Mailing Address: _____ City/State/Zip: _____ Home Phone: _____

Street Address: _____ City/State/Zip: _____ Cell Phone: _____

Parents' Names: _____ Who is responsible for payment of this account? _____

Responsible Person's Address (If divorced or separated): _____ Home Phone: _____

Father's Employer: _____ **SOCIAL SEC. #** _____

Employer's Address: _____ Bus. Phone: _____

Mother's Employer: _____ **SOCIAL SEC. #** _____

Employer's Address: _____ Bus. Phone: _____

Number of Brothers: _____ Sisters: _____ Have they been a patient in this office? _____

Name & Address of Nearest Relative: _____

Nearest Relative's Home or Work # _____ **PATIENT'S SOCIAL SECURITY #:** _____

Family Dentist: _____ Referring Dentist or Doctor: _____

EMAIL ADDRESS: _____

INSURANCE INFORMATION

Name of Dental Insurance - Primary	Name of Policyholder		Date of Birth
Employer	Policy #	Group #	
Additional Dental Insurance - Secondary	Name of Policyholder		Date of Birth
Effective Date Certificate	Policy #	Group #	
Name of Medical Insurance	Name of Policyholder		
Effective Date	Certificate #	Policy #	Group #

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize **Dr. Robert Harrison D.M.D., M.S.D.** to furnish information to insurance carriers concerning my dependent's treatments and I hereby assign to the dentist all payments for his services rendered to my dependents. I understand that I am responsible for any amount not covered by insurance.

DATE _____ **SIGNATURE** _____

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any dental services can be rendered.
Authorization is hereby granted for dental treatment. I will be responsible for any bill incurred on this child for dental treatment.
In an effort to reduce our billing costs so that we can keep your fees down, we require that all fees or estimated co-payments be made on the day of the appointment.

I will be paying today by:

☐ CASH ☐ CHECK ☐ CREDIT CARD ☐ CARECREDIT ☐ MEDICAID

SIGNATURE (Parent or Guardian) _____

OFFICE POLICIES

1. We require 24 hour notices of a cancellation of appointments. If no notice is given a $25.00 charge will be made for each patient.
2. If a sedative appointment is cancelled without 24 hour notice or if the appointment is broken, a $50.00 charge will be made for each patient.
3. As of age 15, most patients will be referred to a general dentist.

OVER

PAST MEDICAL HISTORY

YES NO

1. Does your child see a physician for routine physical examination? _____
   Date of last physical exam? _____
2. Has your child ever had a health problem? _____
3. Has your child ever been under the care of a physician? _____
4. Has your child ever been a patient in a hospital? _____
5. Has your child ever been treated in an emergency room? _____
6. Has your child ever been allergic to anything? List _____
7. Has your child ever taken any medicines? List _____
8. Has your child ever had an unfavorable reaction to any medicine? List _____
9. Has your child ever had any emotional, mental or nervous disorders? _____
10. Please check if your child has had problems with any of the following:

☐ heart disease	☐ diabetes	☐ liver	☐ hearing
☐ heart murmur	☐ asthma	☐ cleft lip/palate	☐ epilepsy/convulsions
☐ bleeding	☐ anemia	☐ kidney	☐ other physical/mental problems

11. What grade is your child in? _____ School child attends: _____
12. Were there any problems at birth? _____
13. Date of Last Tetanus Immunization: _____
14. Child's Physician: _____
15. Current Daily Medications: _____

PAST DENTAL HISTORY

16. What is your main concern about your child's dental health? _____

YES NO

17. Has your child ever been to the dentist? If yes, date of last exam: _____
18. Will your child be an uncooperative patient? _____
19. Has your child ever sucked his fingers or thumb? _____ How long? _____
20. Has your child inherited any family dental characteristics? _____
21. Does your water have fluoride in it? _____
22. Do you give your child any form of fluoride? _____
23. Was your child bottle fed? If yes, at what age was it completely stopped? _____
24. Was your child breast fed? Is yes, at what age was it completely stopped? _____
25. Please check if your child has had problems with any of the following:

☐ cavities	☐ teeth sensitive to hot or cold	☐ crooked teeth
☐ toothache	☐ gum infection	☐ color of teeth
☐ teeth sensitive to sweets	☐ teeth bumped	☐ other dental problems

Comments: _____