WELCOME

William L. Chambers, DDS, MS, PA, Diplomate
Angela P. Baechtold, DDS, MS, PA, Diplomate
Ryan J. Haldeman, DDS, MS, PA
Douglas B. Pratt, DDS, PA, Diplomate
Stephanie S. Chambers, DDS, MS, MSD, Diplomate
Laura P. Hogue, DDS
Anthony Paul Blackman, DMD, MSD
Stephen G. Chadwick, DDS, MSD, MPH

PATIENT INFORMATION

Date _____

Patient's Name _____ Nickname _____ Sex _____
First Middle Last

Physical Address _____

Date of Birth _____ Age _____ Weight _____ Child lives with: ❑ Both parents ❑ Mother ❑ Father ❑ Other

Names of brothers or sisters in practice _____ School Name _____

Patient's Physician or Pediatrician Name _____ Family Dentist _____

Whom may we thank for referring you? _____

RESPONSIBLE PARTY INFORMATION

Name _____ Marital Status: ❑ Single ❑ Separated ❑ Married ❑ Divorced
First Middle Last

Email Address _____ Preferred Phone # _____ Work # _____

Mailing Address _____ ❑ Own ❑ Rent How long at this address _____
Street/P.O. Box City State Zip

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____
(If self-employed, list name of business)

Spouse/(Other) _____ Relationship to Patient _____
First Middle Last

Spouse's/(Other's) Email: _____ Preferred Phone # _____ Work # _____

Mailing Address _____ ❑ Own ❑ Rent How long at this address _____
Street/P.O. Box City State Zip

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____
(If self-employed, list name of business)

DENTAL INSURANCE INFORMATION

Policy Holder's Name _____ Insured's Soc Sec. # _____ Birthdate ____/____/____

Insurance Co. _____ Group No. _____ Subscriber No. _____

Insurance Co. Address _____ Phone No. _____

Policy Holder's Employer _____ Do you have other dental insurance? ❑ Yes ❑ No

EMERGENCY INFORMATION

Name of nearest emergency contact not living with you _____ Phone No. _____

Address _____ Relationship to Patient _____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained.

Parent or Guardian Signature _____ Date _____

10B Yorkshire Street, Asheville, NC 28803
828-274-9220 • fax 828-274-37853

50 Bowman Dr., Waynesville, NC 28785
828-454-9156 • fax 828-454-9158

37 Crestview Heights, Sylva, NC 28779
828-586-9333 • fax 828-586-9248

94 N. Merrimon Ave., Asheville, NC 28804
828-785-5825 • fax 828-785-5826

MEDICAL HISTORY

Has your child ever had any of the following medical problems?

Y	N	Allergies/Asthma	Y	N	Convulsion/Epilepsy	Y	N	Hyperactive
Y	N	Anemia	Y	N	Developmental Delay	Y	N	Lung Problems
Y	N	Austism Spectrum	Y	N	Diabetes	Y	N	Mental Disorder
Y	N	Attention Deficit Disorder	Y	N	Drug/Alcohol Abuse	Y	N	Nervous System Disorder
Y	N	Bleeding Disorder/Hemophilia	Y	N	Fainting	Y	N	Rheumatic Fever
Y	N	Bronchitis	Y	N	Handicap/Disabilities	Y	N	Shunt
Y	N	Cancer/Chemotherapy	Y	N	Hearing Impairment	Y	N	Speech Disorder
Y	N	Cerebral Palsy	Y	N	Hepatitis	Y	N	Tuberculosis
Y	N	Congenital Heart Defect	Y	N	HIV/AIDS	Y	N	Tumors/Growths

Is your child ❑ delayed ❑ normal ❑ advanced in the learning process?

Has your child experienced any other physical or mental disorder that is not listed above? Yes ❑ No ❑

If yes, please describe:_____

Has any immediate family member had any of the above? Yes ❑ No ❑ If Yes, please describe:_____

_____

Is your child allergic to any of the following drugs:

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes ❑ No ❑ If Yes, please list: _____

Is your child allergic to Latex, red dye or anything we need to be aware of? Yes ❑ No ❑ If Yes, please list: _____

_____

Is your child presently under the care of a physician for any illness? Yes ❑ No ❑ If Yes, please list: _____

_____

List any drugs or medicines presently being taken:_____

Has your child ever been hospitalized? Yes ❑ No ❑ If Yes, please give reason and date(s)_____

_____

DENTAL HISTORY

Do you want complete treatment for your child? Yes ❑ No ❑

Reason for appointment: _____

Is this your child's first visit to the dentist? Yes ❑ No ❑ Name of previous dentist:_____

Has your child ever had a serious/difficult problem associated with previous dental work? Yes ❑ No ❑ If Yes, please explain: _____

_____

Date of last dental visit_____ For what service_____

Were any x-rays taken? Yes ❑ No ❑ If Yes, have x-rays been sent to our office? _____

How do you expect your child to behave in our office? _____

Yes	No		Yes	No	
____	____	Does your child brush his/her teeth daily?	____	____	Has an orthodontist been consulted previously? Name:_____
____	____	Do you assist child with tooth brushing?			
____	____	Do you floss your child's teeth?	____	____	Have you been informed of any missing or extra permanent teeth?
____	____	Any mouth habits (thumbsucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)	____	____	Any injuries to mouth, teeth, head? Date(s)_____
____	____	Has child ever had jaw joint pain or tenderness?			
____	____	Is there pain with chewing, yawning, or wide opening?	____	____	Has your child ever had orthodontic treatment?
			____	____	May we request release of your child's medical records?

GROWTH DATA

Yes	No		Yes	No	
____	____	Do you feel your child is still actively growing?	____	____	Females: Has menstruation started? Date:_____
____	____	Males: Has there been a voice change or change in facial hair?			

Thank you for your help. If there is any information that you feel might be of value to us during your treatment of your child, please add it here:

_____

_____

I give my consent to needed dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name)_____. I accept responsibility for payment of services rendered.

Signed (parent or guardian): _____ Date: _____

OFFICE USE ONLY: Doctor's Comments: _____

_____

Great Beginnings

PEDIATRIC & ORTHODONTIC DENTAL SPECIALISTS

Great Smiles

William L. Chambers, DDS, MS, PA, Diplomate • Angela P. Baechtold, DDS, MS, PA, Diplomate
Ryan J. Haldeman, DDS, MS, PA • Douglas B. Pratt, DDS, PA, Diplomate • Stephanie S. Chambers, DDS, MS, MSD, Diplomate
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COMPOUND AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient _____ Date of Birth _____

Great Beginnings and Great Smiles Pediatric and Orthodontic Dental Specialists is authorized to release protected health information about the above named patient to the entities named below. The purpose is to inform the patient or others in keeping with the patient's instructions.

1. Can confidential messages including appointment reminders, x-ray results, insurance, financials/billing or other healthcare information be left on your home answering machine or voicemail? (circle one) **YES** **NO**

   Our office sends email communications in an encrypted manner. Email and text messages are used for third party appointment information and office news. This information is not shared with solicitors.

2. Can we send emails? (circle one) **YES** **NO**
3. Can we send text messages? (circle one) **YES** **NO**
4. Please list the family member(s) or other persons with names and phone numbers. If any, whom we may inform about your appointments, labs, and x-ray results or other healthcare information, insurance, financial and billing information.

Name	Relationship to Patient	Financial	Dental Treatment
_____	_____	☐	☐
_____	_____	☐	☐
_____	_____	☐	☐

PATIENT RIGHTS:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

The information is released at the patient's request and this authorization will remain in effect until revoked by the patient.

Signature of Patient
or Personal Representative _____ Date _____

*Description of personal Representative's Authority (attach documentation if necessary) _____

_____

FOR INSURANCE PURPOSES:

PLEASE SIGN AND RETURN IMMEDIATELY

*Patient's name:*_____

Employee name: _____

AUTHORIZATION TO RELEASE INFORMATION – I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable.

AUTHORIZATION TO PAY BENEFITS TO DENTIST – I hereby authorize payment directly to the below-named Dentist of the Dental Benefits otherwise payable to me.

Great Beginnings Pediatric Dental Specialists & Great Smiles Orthodontic Specialists

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SIGNED:_____DATE: _____

Thank you for your cooperation.

Great Beginnings

PEDIATRIC & ORTHODONTIC DENTAL SPECIALISTS

Great Smiles

IT'S ALL ABOUT YOU!

Name _____ Nickname _____ Age_____

My hobbies are _____

I have a pet_____and its name is _____

My favorite food is_____

I go to school at _____ and I'm in Grade___

What I want to be when I grow up: _____

How I feel about visiting the dentist:_____

My question(s) for the doctor: _____

_____

_____

BeGreatDental.com