Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	O Yes O No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	O Yes O No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	O Yes O No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	O Yes O No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	O Yes O No	If yes, please explain: _____
Are you on a special diet?	O Yes O No	If yes, please explain: _____
Do you use tobacco, vape, or e-cigarettes?	O Yes O No	If yes, please explain: _____
Do you use controlled substances?	O Yes O No	If yes, please explain: _____

Women: Are you
Pregnant/Trying to get pregnant? O Yes O No Taking oral contraceptives? O Yes O No Nursing? O Yes O No

Are you allergic to any of the following?
O Aspirin O Penicillin O Codeine O Acrylic O Metal O Latex O Local Anesthetics
O Other - If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Renal Dialysis	O Yes O No
Alzheimer's disease	O Yes O No	Diabetes	O Yes O No	Hepatitis A	O Yes O No	Rheumatic Fever	O Yes O No
Anaphylaxis	O Yes O No	Drug Addiction	O Yes O No	Hepatitis B or C	O Yes O No	Rheumatism	O Yes O No
Anemia	O Yes O No	Easily Winded	O Yes O No	Herpes	O Yes O No	Scarlet Fever	O Yes O No
Angina	O Yes O No	Emphysema	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Epilepsy or Seizures	O Yes O No	Hives or Rash	O Yes O No	Sickle Cell Disease	O Yes O No
Artificial Heart Valve	O Yes O No	Excessive Bleeding	O Yes O No	Hypoglycemia	O Yes O No	Sinus Trouble	O Yes O No
Artificial Joint	O Yes O No	Excessive Thirst	O Yes O No	Irregular Heartbeat	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness		Kidney Problems	O Yes O No	Stomach/Intestinal Disease	
Blood Disease	O Yes O No		O Yes O No	Leukemia	O Yes O No		O Yes O No
Breathing Problem	O Yes O No	Frequent Cough	O Yes O No	Liver Disease	O Yes O No	Stroke	O Yes O No
Bruise Easily	O Yes O No	Frequent Diarrhea	O Yes O No	Low Blood Pressure	O Yes O No	Swelling of Limbs	O Yes O No
Cancer	O Yes O No	Frequent Headaches	O Yes O No	Lung Disease	O Yes O No	Thyroid Disease	O Yes O No
Chemotherapy	O Yes O No	Genital Herpes	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tonsillitis	O Yes O No
Chest Pains	O Yes O No	Hay Fever	O Yes O No	Pain in Jaw Joints	O Yes O No	Tuberculosis	O Yes O No
Cold Sores/Fever Blisters		Heart Attack/Failure	O Yes O No	Parathyroid Disease	O Yes O No	Tumors or Growths	O Yes O No
	O Yes O No	Heart Murmur	O Yes O No	Psychiatric Care	O Yes O No	Ulcers	O Yes O No
Congenital Heart Disorder		Heart Pace Maker	O Yes O No	Radiation Treatments	O Yes O No	Venereal Disease	O Yes O No
	O Yes O No	Heart Trouble/Disease		Recent Weight Loss	O Yes O No	Yellow Jaundice	O Yes O No
Convulsions	O Yes O No		O Yes O No				

Have you ever had any serious illness not listed above? O Yes O No - If yes, please explain: _____
Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, Guardian _____ Date _____

Kintegra Health

Pediatrics
CONSENT FOR EVALUATION OF
TREATMENT AND RIGHT TO REFUSE TREATMENT

PATIENT INFORMATION ***DATE OF COMPLETION (mm/dd/yyyy):*** ____/____/____

Patients Legal Name (Last, First, Middle)	Preferred Name:

Demographics:

Date Of Birth (MM/DD/YYYY) ____/____/____	***Birth Sex:*** ☐ Female ☐ Male ☐ Other ☐ Undefined ***Gender Identity:*** ☐ Female ☐ Transgender Female/Trans Woman/ Male-to-Female (MTF) ☐Male ☐Transgender Male/ Trans Male/ Female-to-Male (FTM) ☐ Gender (neither exclusively male or female) ☐ Additional gender/ Other. Please specify: _____ ☐Chose not to answer
Home Phone Number: Home: (____) _____-_____ Cell: (____) _____-_____	*The child lives with:* ☐ Both Parents ☐ Parent 1 ☐ Parent 2 ☐ Grandparent : _____ Legal Guardian: _____ Person Acting in Place of Parent: _____

Race: ☐ Black / African American ☐ More than one race ☐ White ☐ Asian
☐ American Indian /Alaska Native ☐ Native Hawaiian ☐ Other Pacific Islander
☐ Unreported /Refuse to report race

Preferred Method of Communication:
☐ Postal Mail ☐ Phone ☐ Email /Text ☐ Web Message

Parent 1 / Guardian(s) Information: ☐ Emergency Contact			*Parent 2 / Guardian(s) Information:* ☐ Emergency Contact		
Date of Birth ____/____/____	*Sex:* ☐ Female ☐ Male	*SSN:* ___-___-_____	*Date of Birth* ____/____/____	*Sex:* ☐ Female ☐ Male	*SSN:* ___-___-_____
Address:			*Address:*		
City	*State*	*Zip*	*City*	*State*	*Zip*
ome Phone	*Work Phone*	*Cell Phone*	*Home Phone*	*Work Phone*	*Cell Phone*
E-Mail Address	*Employer Name*		*E-Mail Address*	*Employer Name*	

Additional Emergency Contact Information:

Name: _____ *Relationship:* _____
Phone Number: _____

Insurance Information:					
Primary:			***Secondary/Supplemental:***		
Name of Plan:			*Name of Plan:*		
Claims Address (Street Address / P.O Box)			*Claims Address (Street Address / P.O Box)*		
City	*State*	*Zip*			
Phone Number			*Phone Number*		
Policy Number	*Group Number*		*Policy Number*	*Group Number*	
Subscriber Name (If different from patient - Last, First, Middle)			*Subscriber Name (If different from patient - Last, First, Middle)*		
Effective Date:	*Expiration Date:*		*Effective Date:*	*Expiration Date:*	
Guarantor Name:	*Employer:*		*Guarantor Name:*	*Employer:*	
Co-pay Amount:	*Relationship to Patient:*		*Co-pay Amount:*	*Relationship to Patient:*	
Plan Type: ☐ Medicaid ☐ PPO ☐ HMO ☐ POS ☐ Self Pay			*Plan Type:* ☐ Medicaid ☐ PPO ☐ HMO ☐ POS ☐ Self Pay		
Person Responsible for Payment of Bill: ☐ Mother ☐ Father ☐ Guardian or Other: _____					
HOW DID YOU HEAR ABOUT US? _____					

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS:

Consent for Healthcare and Release of Medical Information: I voluntarily consent to healthcare treatment (i.e., Medical Care and/or Behavioral Health) from the Medical and Behavioral Health providers, and staff of Kintegra Health. I consent to all necessary treatment of illness and injuries and preventative care including screenings, lab work (including HIV testing), immunizations and referrals. I am aware that neither the practice of medicine nor the delivery of mental/behavioral health treatment are an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that Kintegra Health employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between Kintegra Health providers and staff members involved in my care to ensure appropriate treatment planning and adequate care. I consent to the use and disclosure of Protected Health Information (PHI) about me for treatment, payment and healthcare operations. I understand that I am automatically enrolled in the Health Information Exchange, but at any time can opt-out by completing an Opt-Out Form provided by my provider. I certify that I have read and understand this form.

This consent is renewable annually. I may withdraw authorization for medical or behavioral health services at any time.

Footnote: Kintegra Health, with headquarters in Gastonia, North Carolina, includes Kintegra Medical, Dental, Integrated Medicine, and Behavioral Health Practices throughout North Carolina. Affiliate: Local Health Departments: Catawba, Davie, Davidson, Forsyth, Gaston, Iredell, Lincoln, Mecklenburg.

CONFIDENTIAL SERVICES: I understand that North Carolina General Statutes Section 90 – 21.5 protects a minor's right to receive services relating to sexually transmitted diseases, pregnancy, drug abuse and emotional disturbances without parental consent. I understand that according to NC General Statutes 90 – 21.4 medical providers are not required to notify me about services provided in these areas unless the situation, in the opinion of the medial provider, indicates that notification is essential to the life or health of the minor. I understand that if I request information about these services, the medical provider will share information with me only if the provider considers it in the best interest of my child's health and welfare to do so. I further understand that the GFHS and all its affiliates will make every effort to encourage my child to discuss problems and services with me.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF INSURANCE BENEFITS: I guarantee payment to Kintegra Health and its affiliates for all charges for services provided to my child unless specifically waived based on family size and income, in accordance with the Kintegra Health billing policy. I understand I am personally responsible for all charges not covered by insurance. I authorize payment of medical, surgical and behavioral benefits, which would otherwise be payable to me, to GFHS for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, VVIII and/or XIX of the Social Security Act is correct.

Parent / Legal Guardian / Person Acting in Place of the Parent:

Date: _____

Print: _____ Signature: _____

FOR OFFICE USE ONLY:

_____ _____

Witness Signature Date / Time

☐ Patient refused to sign

☐ Patient was initially treated for an emergency. Patient was either: (Choose One)

- Given the notice after stabilization ***Or***
- Will be given the notice after transfer

If limited English proficient or hearing impaired, offer interpreter services at no additional cost:

State native language: _____

☐ LEP: Interpreter accepted _____ ☐ LEP: Interpreter Refused: _____

Name / Number of Person/Services Chosen/Used

Consent to Treat- Revised Jan 2020

Permission to Communicate - Authorization for Release of Information

Name of Patient _____ Date of Birth (MM/DD/YYYY) _____

_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Facility Name

So that Kintegra Health may serve you better, you have the option of providing us with a list of caregivers with whom we may discuss your appointments, referrals, test, lab results and any other health information you desire us to share.

Describe how information will be received. Check each person/entity that you approve to receive information.	**Describe the information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail ☐ Mail	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Other_____
☐ Other person(s): Name / Phone Number / Relationship _____ _____ _____	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Other _____
☐ Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	☐ Medical (Appointments, referrals, test and lab results and any other health information) ☐ Financial ☐ Breach notification
☐ Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	☐ Appointment reminder ☐ Other: _____

☐ *For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.

☐ Photo of patient received by patient or legal guardian	☐ May be posted in office
☐ Photo taken by staff (Example: pre/post procedure)	☐ May be posted on website
☐ Other	☐ Other_____

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.
- I understand I am automatically enrolled in the Health Information Exchanges, but at any time can opt-out by completing an Opt-Out form provided by my provider.

This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

_____

☐ I am revoking my authorization to disclose the previously requested protected health information.

_____ Date _____

Signature of Patient or Personal Representative

Revised January 2020

Kintegra Health
Office Policies for all Dental Practices

New Patients: Please arrive thirty (30) minutes early for patient registration.
Emergencies: Patients are only allowed one (1) emergency appointment as a new patient. The next appointment will be for an exam, cleaning, and x-rays.
Sliding Fee Scale: Proof of income is required at the first appointment. If this is not provided, you will be charged our full fee until income information has been provided to us. All information needs to be updated yearly.
Late Arrivals: If you arrive more than ten (10) minutes late for your appointment, you may be asked to reschedule your appointment so that we will have enough time to complete your treatment. This is up to the discretion of the dentist.
Cancellations: When canceling an appointment, you must give at least twenty-four (24) hours' notice. Anything less than six (6) hours is viewed as a missed appointment. When a patient misses an appointment, we miss the opportunity to care for that patient as well as another patient who could have used that appointment slot.

NO CALL/NO SHOW

- First missed appointment: A note will be placed in the chart and the patient verbally reminded of our office policy.
- Second Missed appointment: A note will be placed in the chart, the patient verbally reminded again of our office policy, and the patient will not be allowed to reschedule for three (3) months.

Adults only: A letter must be written to our Dental Director stating the following:

1. Why you missed the last appointment
2. Why you feel you need another appointment
3. Also that you realize you took time where someone else could have been seen.
4. Also that you realize that if you miss another appointment, it will result in your discharge from the practice for 1 year.

- Third Missed appointment: The Patient will not be allowed to make advance appointments for a period of one (1) year, except for emergencies.
- If a patient is scheduled with another family member and they both fail to show for their appointments, the family will no longer be able to schedule multiple appointments on the same day.

Children's escorts: We appreciate your trust in our dental staff as we provide dental treatment to your child. Our rooms are small and we prefer that only one parent come back with a young child. Children age 6 and over may be escorted to the treatment room by our staff. Before your child is taken back, our staff will discuss with you any dental problems your child is experiencing and any changes in their medical history. Parents of older children are encouraged to allow their children some independence at the dentist's office, but are never prohibited from coming back with their children. In addition, parents that have dental anxiety themselves may find that their children have a more positive experience without them in the back. Our ultimate goal is to give your child the most chances to succeed in their dental treatment so that they may carry this confidence throughout the rest of their lives.

Photography: Please discuss taking photos and video for your personal use with the dentist. We do take photos of our patients at times, but only with your advance permission.

I understand and agree to abide by this no-show policy.

Patient/Parent signature_____ Date: _____

Kintegra Health

Patient label

AUTHORIZATION FOR TREATMENT IN PARENT(S) ABSENCE

In the event that the parent(s) or guardian(s) of this child is unable to accompany the child to an office visit, unable to be reached, or in the case of an emergency, we the parent(s) or legal guardian(s) of _____, authorize the physicians of Kintegra Health to administer such medical care as indicated due to illness, (medical, behavioral, and/or surgical) and further consent that such treatment, procedures, medical consults, behavioral consults, surgical consults and operative procedures that are indicated to be carried out.

I understand I am automatically enrolled in the Health Information Exchanges, but at any time can opt-out by completing an Opt-Out form provided by my provider.

Listed below are persons who are authorized to bring my child for medical care:

1) _____ _____
Name of authorized person Relationship to the patient

2) _____ _____
Name of authorized person Relationship to the patient

3) _____ _____
Name of authorized person Relationship to the patient

_____ _____ _____
Parent or Legal Guardian Signature of Witness Date

Kintegra Health

Patient label

NOTICE OF PRIVACY PRACTICE

ACKNOWLEDGEMENT FORM

We are required by law to provide you with our Notice of Privacy Practices which explains how we use and disclose your health information. We are also required to obtain your signature acknowledging that this notice has been made available to you as follows:

☐ http://www.kintegra.org

☐ By writing to the Kintegra Health Privacy Officer, 200 E. Second Avenue, Gastonia, NC 28052

☐ Or by requesting one at any GFHS provider locations

Signature: _____ Date: _____/_____/_____

(Patient or Authorized Representative)

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent/Guardian ☐ Other: _____

Reason patient unable / unwilling to sign: _____

_____