

Put Patient

Label

Here

**Medical History**

If you need help completing this form, let us know.



Patient: \_\_\_\_\_

(please print full name)

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 as they relate to the above-named patient.

Do you have a primary care physician? ☐ Yes ☐ NoAre you under the care of a specialist? ☐ Yes ☐ NoAre you on a special diet? ☐ Yes ☐ NoDo you use tobacco, vape, or e-cigarettes? ☐ Yes ☐ NoDo you use controlled substances? ☐ Yes ☐ NoHave you ever been hospitalized or had a major operation? ☐ Yes ☐ NoHave you ever had a serious head or neck injury? ☐ Yes ☐ No\*If you answered yes to any of these questions, please explain in the **Comments** section at the bottom of this page.Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

\*Please List all medications and dosages. If more space is needed, please use the back of this form.

Do you take, or have you taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates (bone strengthening medications for osteoporosis and other bone conditions). ☐ Yes ☐ No

Head and neck radiation ☐ Yes ☐ NoAre you allergic to any of the following? ☐ No known allergies☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics ☐ Other - If yes: \_\_\_\_\_**Women:**Are you pregnant/trying to get pregnant? ☐ Yes ☐ No Are you taking oral contraceptives? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Do you have, or have you had, any of the following? One box for each condition must be marked:

Acid Reflux <input type="checkbox"/> Yes <input type="checkbox"/> No	Cold Sores/Fever Blisters <input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis B or C <input type="checkbox"/> Yes <input type="checkbox"/> No	Seasonal Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD <input type="checkbox"/> Yes <input type="checkbox"/> No	Congenital Heart Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No	Depression <input type="checkbox"/> Yes <input type="checkbox"/> No	High Cholesterol <input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No
Alzheimer's <input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash <input type="checkbox"/> Yes <input type="checkbox"/> No	Sleep Apnea <input type="checkbox"/> Yes <input type="checkbox"/> No
Severe allergic Reaction <input type="checkbox"/> Yes <input type="checkbox"/> No	Dry Mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia (low sugar) <input type="checkbox"/> Yes <input type="checkbox"/> No	Steroid Medications (for >2 weeks) <input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Drug Addiction <input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular Heartbeat <input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No	(Past or present) <input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Problems <input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis/Gout <input type="checkbox"/> Yes <input type="checkbox"/> No	Emphysema - COPD <input type="checkbox"/> Yes <input type="checkbox"/> No	Leukemia <input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valve <input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy or Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Teeth Grinding <input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joint <input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease <input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting Spells/Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No
Autism/Spectrum Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches/Migraines <input type="checkbox"/> Yes <input type="checkbox"/> No	Osteoporosis <input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No
Auto Immune Disorder <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain in Jaw Joints (TMJ) <input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths <input type="checkbox"/> Yes <input type="checkbox"/> No
Bruise Easily <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Attack/Failure <input type="checkbox"/> Yes <input type="checkbox"/> No	Premedication <input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No	STI/STD <input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Pace Maker <input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No	Visual Impairment <input type="checkbox"/> Yes <input type="checkbox"/> No
Chest Pains <input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Trouble/Disease <input type="checkbox"/> Yes <input type="checkbox"/> No	Renal Dialysis <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hemophilia (Blood Disease) <input type="checkbox"/> Yes <input type="checkbox"/> No	Shingles <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Hepatitis A <input type="checkbox"/> Yes <input type="checkbox"/> No	Shunts <input type="checkbox"/> Yes <input type="checkbox"/> No	

Have you ever had any medical Conditions not listed above? ☐ Yes ☐ No. If yes, please explain in the **Comments** section**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 \_\_\_\_\_

**PATIENT DEMOGRAPHICS**
**DATE OF COMPLETION** (mm/dd/yyyy): \_\_\_\_\_

<b>Legal Name (Last, First, MI):</b>		<b>Preferred Name:</b>	
<b>Primary Doctor:</b>		<b>Date of Birth</b> (mm/dd/yyyy):	<b>SSN:</b>
<b><u>Race:</u></b> <input type="checkbox"/> Asian Indian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Japanese <input type="checkbox"/> Koren <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Native Hawaiian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> Guamanian or Chamorro <input type="checkbox"/> Samoan <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> White <input type="checkbox"/> More than one race <input type="checkbox"/> Unreported/Chose Not to Disclose		<b><u>The child lives with:</u></b> <input type="checkbox"/> Both parents <input type="checkbox"/> Parent 1 <input type="checkbox"/> Parent 2 <input type="checkbox"/> Grandparent: _____ Legal Guardian: _____ Person Acting in Place of Parent: _____  <b><u>Parent 1/Guardian Information:</u></b> Name: _____ DOB: ____/____/____ SSN: ____-____-____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male Address: _____ City: _____ State: _____ Zip: _____ Email Address: _____ Employer Name: _____  <b><u>Parent 2/Guardian Information:</u></b> Name: _____ DOB: ____/____/____ SSN: ____-____-____ Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male Address: _____ City: _____ State: _____ Zip: _____ Email Address: _____ Employer Name: _____	
<b><u>Ethnicity:</u></b> <input type="checkbox"/> Mexican/Mexican American/Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Cuban <input type="checkbox"/> Another Hispanic/Latino(a)/Spanish Origin <input type="checkbox"/> Hispanic/Latino(a)/Spanish Origin/Combined <input type="checkbox"/> Non-Hispanic/Latino(a) <input type="checkbox"/> Unreported/Chose Not to Disclose			
<b><u>Birth Sex:</u></b> <input type="checkbox"/> Female <input type="checkbox"/> Male <input type="checkbox"/> Other <input type="checkbox"/> Undefined			
<b>Home Address:</b>		<b>City</b>	<b>NC</b>
<b>Home Phone:</b>		<b>Cell Phone:</b>	<b>Work Phone:</b>
<b>Preferred method of communication:</b>		<b>Email Address:</b>	
<input type="checkbox"/> Postal Mail <input type="checkbox"/> Phone <input type="checkbox"/> Email / Text			
<b>Responsible Party:</b>		<b>Relationship:</b>	<b>Date of Birth</b> (mm/dd/yyyy):
<b>Responsible Party Home Address:</b>		<b>City</b>	<b>NC</b>
		<b>Zip code</b>	

**INSURANCE INFORMATION**

Primary Insured's Name: _____		Secondary Insured's Name: _____	
Date of Birth (mm/dd/yyyy)   SSN: _____ - _____ - _____ ____ / ____ / ____		Date of Birth (mm/dd/yyyy)   SSN: _____ - _____ - _____ ____ / ____ / ____	
Primary Insurance:	Employer:	Secondary Insurance:	Employer:
Relationship to Patient:		Relationship to Patient:	
Insurance ID Number:	Group Number:	Insurance ID Number:	Group Number:
Primary Insurance Address:		City	NC Zip code
Secondary Insurance Address:		City	NC Zip code

Signature of Parent/Legal Guardian: _____ Date/Time _____	
Printed Name of Parent/Legal Guardian : _____	
Insured Party or Financial Guarantor (if different from above): _____ Date/Time _____	

We at Kintegra Health are committed to providing the highest quality care to our patients. We expect our patients to behave in a manner that is respectful to our staff and other patients. In order to ensure a safe and comfortable environment for everyone, we ask that you abide by the following code of conduct:

**Respect**

Patients should respect the healthcare professionals treating them, as well as other patients in the facility. This includes refraining from any type of verbal or physical abuse, discriminatory language, or any other behavior that may be offensive to others. Patients should also respect the privacy and confidentiality of other patients, as well as their own.

**Communication**

Patients should communicate openly and honestly with their healthcare providers. This includes providing accurate information about their medical history, symptoms, and any medications or treatments they are currently receiving. Patients should also ask questions and seek clarification, when necessary, to ensure they have a clear understanding of their diagnosis, treatment plan, and any other medical issues.

**Compliance**

Patients should follow the treatment plan prescribed by their healthcare provider. This includes taking medications as directed, attending scheduled appointments, and following any other instructions or recommendations provided by their healthcare team. Patients should also inform their healthcare provider of any changes in their health or medical condition.

**Safety**

Patients should take responsibility for their own safety and well-being. This includes informing their healthcare provider of any allergies or adverse reactions to medications, reporting any incidents or concerns related to safety, and following all safety guidelines and protocols established by the healthcare facility.

**Environment**

Patients should respect the healthcare facility and its resources. This includes keeping the facility clean, following all rules and regulations, and using resources appropriately.

**Appointments**

Patients should keep all scheduled appointments or notify the practice 24 hours in advance if there is a need to cancel. Excessive No-Shows may lead to discharge from Kintegra Health services.

We reserve the right to refuse service to any patient who does not comply with this code of conduct. We appreciate your cooperation in helping us maintain a safe and respectful environment for everyone.

**Acknowledgement**

I have read Kintegra Health's Patient Code of Conduct and I understand and agree to abide by the COC.

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Patient Signature

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Date

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Parent/Guardian Signature (If applicable)

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Date

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Consent for Healthcare and Release of Personal Health Information:**

I voluntarily consent to healthcare treatment (i.e., Dental, Medical Care, and/or Behavioral Health) for my child from the providers and staff of Kintegra Health, Inc. and all its affiliates. 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 is an exact science. No guarantees have been made to me regarding the results of treatments or examinations by my caregivers. I understand that Kintegra employs a "team based" approach to the delivery of healthcare and that health information may be exchanged between Kintegra 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. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Title's V, XVIII, and/or XIX of the Social Security Act is correct. I certify that I have read and understand this form. 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 understand that North Carolina 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 medical 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 Kintegra Health and all its affiliates will make every effort to encourage my child to discuss problems and services with me. This consent is renewable annually. I may withdraw authorization for services at any time. Initial \_\_\_\_\_

**Notice of Privacy Practice Acknowledgement:**

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 Kintegra Health Privacy Office, 200 E. Second Ave, Gastonia, NC 28052, or by requesting one at any Kintegra Health Provider locations. Initial \_\_\_\_\_

**Financial Responsibility and Assignment of Insurance Benefits:**

I guarantee payment to Kintegra Health and its affiliates for all charges for services provided to me 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 health benefits, which would otherwise be payable to me, to Kintegra Health for services rendered. If covered by Medicare or Medicaid, I certify that the information provided by me in applying for payment under Titles V, VIII, and/or XIX of the Social Security Act is correct. Initial \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient or Authorized Person

\_\_\_\_\_  
Date

\_\_\_\_\_  
Insured Party or Financial Guarantor (if different from above)

\_\_\_\_\_  
Date

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, Cleveland, Davie, Davidson, Forsyth, Gaston, Iredell, Lincoln, Mecklenburg.



## **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. 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: \_\_\_\_\_



Patient Label  
Or

Printed Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

MRN \_\_\_\_\_

## Kintegra Health Communication Consent

I give permission to Kintegra Health to contact me on my cell phone, home and/or work phone using prerecorded messages, artificial voice messages, automatic dialing devices or other computer assisted technology, or by e-mail, text messaging, or by any other form of electronic communication, based on my communication preferences. Standard messaging rates may apply. Information sent via these methods may include billing and payment, appointment, and/or medical information.

I understand that for e-mail and/or text communication that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive e-mail and/or text communications.

This disclosure form is in effect until changed or revoked by me. Only I can change who is named on this form to communicate with Kintegra Health about my health information. At the time of change or revocation, I will complete a new form. Emergency contacts are not included in this consent.

I understand that the release of copies of my medical records requires a specific authorization form signed by myself or my legal representative. These communications may occur when the identified person(s) joins me at my visit, or communicates for me by telephone, e-mail, or other electronic method.

I give permission for Kintegra Health to communicate with the following person(s) regarding:

- ☐ My billing and payment information.
- ☐ Appointment management, including scheduling, cancelling, and rescheduling of appointments.
- ☐ Medical information, including diagnosis, results, and treatment plans.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

- ☐ I decline any communication with others outside of myself or legal guardian(s).
- ☐ I opt out of any communication except for appointment reminders.

Signature: \_\_\_\_\_  
(Patient or person legally authorized to sign for patient)

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_



## CONSENT FOR SERVICES

### PLEASE READ CAREFULLY AND SIGN BELOW:

I have been informed of the type of services I will receive, and I voluntarily consent for myself and/or my child \_\_\_\_\_ to be examined and evaluated by the Kintegra Pediatric Dentistry staff. I agree for routine tests to be administered as deemed necessary. Included in this agreement is permission for treatment as indicated and referral to other appropriate health care facilities when necessary. I have been informed of both the risks and benefits of the examination, laboratory tests, and the treatment provided.

I authorize the release of any medical or other information necessary to process medical claims.

### 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 and/or Gaston County Health Department to administer such medical care as indicated due to illness, (medical and/or surgical) and further consent that such treatment, procedures, medical consults, surgical consults, and operative procedures that are indicated to be carried out.

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

- |                                       |                                  |
|---------------------------------------|----------------------------------|
| 1) _____<br>Name of authorized person | _____<br>Relationship to patient |
| 2) _____<br>Name of authorized person | _____<br>Relationship to patient |
| 3) _____<br>Name of authorized person | _____<br>Relationship to patient |

\_\_\_\_\_  
Parent or Legal Guardian (Print)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date