Put Patient Label Here

Medical History

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

Kintegra Health

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 ☐ No
Are you under the care of a specialist? ☐ Yes ☐ No
Are you on a special diet? ☐ Yes ☐ No
Do you use tobacco, vape, or e-cigarettes? ☐ Yes ☐ No
Do you use controlled substances? ☐ Yes ☐ No
Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No
Have 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 ☐ No

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

Kintegra Health

PEDIATRIC - Patient Information

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

Legal Name (Last, First, MI):	***Preferred Name:***	
Primary Doctor:	***Date of Birth*** (mm/dd/yyyy):	**SSN**:

Race:

☐ Asian Indian ☐ Chinese
☐ Filipino ☐ Japanese
☐ Koren ☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Other Pacific Islander
☐ Guamanian or Chamorro
☐ Samoan
☐ Black/African American
☐ American Indian/Alaska Native
☐ White
☐ More than one race
☐ Unreported/Chose Not to Disclose

Ethnicity:

☐ Mexican/Mexican American/Chicano
☐ Puerto Rican ☐ Cuban
☐ Another Hispanic/Latino(a)/Spanish Origin
☐ Hispanic/Latino(a)/Spanish Origin/Combined
☐ Non-Hispanic/Latino(a)
☐ Unreported/Chose Not to Disclose

Birth Sex:

☐ Female ☐ Male ☐ Other
☐ Undefined

The child lives with:

☐ Both parents ☐ Parent 1 ☐ Parent 2

☐ Grandparent: _____

Legal Guardian: _____

Person Acting in Place of Parent: _____

Parent 1/Guardian Information:

Name: _____

DOB: ____/____/_____ **SSN:** ____-_____-_____ **Sex:** ☐ Female ☐ Male

Address:_____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Employer Name: _____

Parent 2/Guardian Information:

Name: _____

DOB: ____/____/_____ **SSN:** ____-_____-_____ **Sex:** ☐ Female ☐ Male

Address:_____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Employer Name: _____

Home Address:	***City***	***NC***	***Zip code***

Home Phone: ***Cell Phone:*** ***Work Phone:*** ***Email Address:***

Preferred method of communication: ☐ Postal Mail ☐ Phone ☐ Email / Text

Responsible Party:	***Relationship:***	***Date of Birth*** (mm/dd/yyyy):	**SSN**:

Responsible Party Home Address:	***City***	***NC***	***Zip code***

INSURANCE INFORMATION

Primary Insured's Name: _____ ***Date of Birth (mm/dd/yyyy)*** | ***SSN:*** _____-_____-_____ _____ /_____ /_____			***Secondary Insured's Name:*** _____ ***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***_____

Patient Code of Conduct

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.

_____ _____
Patient Signature Date

_____ _____
Parent/Guardian Signature (If applicable) 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) 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. I understand that my medical information could include medical history or information regarding diagnosis and treatment for a communicable disease (such as a sexually transmitted infection, HIV/AIDS or hepatitis), mental illness, alcohol or substance use. 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. 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, incudes 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.Nov. 2022

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: _____ Date: _____
(Patient or person legally authorized to sign for patient)

Printed Name: _____

Kintegra
Pediatric Dentistry

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) _____ _____
Name of authorized person Relationship to patient

2) _____ _____
Name of authorized person Relationship to patient

3) _____ _____
Name of authorized person Relationship to patient

_____ _____ _____
Parent or Legal Guardian (Print) (Signature) Date

_____ _____
Signature of Witness Date