Chapel Hill Pediatric Dentistry
Avni C. Rampersaud, D.D.S., P.A.
919.929.0489

I. General Information

Date: ____/_____/_____

Patient:_____

Last *First* *Middle*

Child's Preferred Name: _____ Sex (please circle): Male Female Age:_____

Date of birth: _____/_____/_____ Place of Birth: _____

Home Address:_____

Street Address

_____ Home Phone: _____

City *State* *Zip*

Email Address: _____ Cell Phone:_____

Parent/Guardian: _____

Occupation: _____ Employer's Name:_____ Phone:_____

Parent/Guardian:

_____

Occupation: _____ Employer's Name: _____ Phone:_____

Person responsible for payment of account:_____

Legal Guardian(s) of Patient:_____

Emergency Contact Person:_____**Phone:**_____

Whom may we thank for referring you to our office? _____

What number may we leave a message regarding your child's appointment and/or account information?

_____

Child's School:_____ Grade:_____

Child's Primary Language: _____ Parent's Primary Language:_____

Names & ages of siblings:_____

Names of child's pets:_____

What are your child's interests? _____

II. Medical History

Child's Pediatrician / Physician: _____Phone:_____

Name of Practice: _____

Parent's Dentist: _____

Does your child have a history of any of the following? Please circle.

YES NO Allergies
YES NO Asthma
YES NO Autism
YES NO Bleeding Disorders
YES NO Bronchitis
YES NO Cancer/Tumors
YES NO Cerebral Palsy
YES NO Cleft Lip/Palate
YES NO Diabetes
YES NO Ear Infections
YES NO Ear Tubes
YES NO Epilepsy
YES NO Eyes or Eyesight Disorder
YES NO Fainting
YES NO Feeding/Eating Problems
YES NO Gastrointestinal Disorder
YES NO HIV
YES NO Hearing/Speech Disorder
YES NO Heart Disease
YES NO Heart Murmur
YES NO Hepatitis
YES NO Hyperactivity or ADHD
YES NO Jaundice
YES NO Kidney or Liver Disease
YES NO Lung Problems
YES NO Mental Disorder
YES NO Nervous Disorder
YES NO Rheumatic Fever
YES NO Seasonal Allergies
YES NO Seizures
YES NO Sickle Cell Disease/Trait
YES NO Sleep Apnea
YES NO Spina Bifida
YES NO Sensory Integration Disorder

Other physical or medical disorders:_____

_____

YES NO Has any immediate family member had any of the above? If "yes," please describe:

_____

YES NO Were there any difficulties during pregnancy, delivery, or the first year of the child's life? If "yes," please explain:_____

YES NO Was birth premature? If "yes," please explain: _____

YES NO Has your child ever had general anesthesia? If "yes," please explain:

_____

YES NO Has your child ever been hospitalized? If "yes," please explain:_____

YES NO Is your child currently taking any medications? If "yes," please list medication and dosage:

_____

Has your child had any allergic reactions to:

YES NO Medications or drugs {such as penicillin, aspirin, or lidocaine (local anesthetic)}?

YES NO Latex?

YES NO Foods?

YES NO Food coloring/additives?

If "yes, " please list and describe reaction:

_____

YES NO Have you ever been informed that your child needs to take antibiotics prior to dental treatment? If "yes," please explain:

_____

YES NO Would you consider your child to be in good health at the present time? If "no," please explain:

_____

Date of last physical examination by pediatrician/physician? _____

YES NO Are your child's immunizations current?_____

III. Dental History

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

_____

YES NO Is this your child's first visit to the dentist?

If "no," date of last dental visit _____/_____/____ Service performed: _____

YES NO Have X-rays been taken?

X-rays are often necessary for a thorough dental exam.

YES NO Do we have your permission to take diagnostic x-rays if needed?

YES NO Has your child ever complained about a dental problem or had any unhappy dental experiences? Please explain:

_____

_____

YES NO Was your child breast-fed? If "yes," for how long?_____

YES NO Was your child bottle-fed? If "yes," for how long?_____

YES NO Sleeps or slept with bottle/sippy cup?

Did your child get his/her teeth… please circle one: EARLY ON TIME LATE

Does (did) your child have any of the following habits?

YES NO Thumb/Finger sucking
YES NO Nail biting
YES NO Mouth breathing
YES NO Pacifier sucking
YES NO Night time grinding

Please circle if your child has/had/or may have ANY of the following dental problems:

YES NO Cavities
YES NO Teeth sensitive to sweets
YES NO Teeth sensitive to hot/cold
YES NO Gum infection/abscess
YES NO Teeth bumped or chipped
YES NO Discoloration of teeth
YES NO Cold sores/fever blisters/mouth ulcers
YES NO Pain and/or noise with opening

Is there anything else you would like us to know regarding your child's dental health history?

_____

_____

Who brushes your child's teeth? please circle: CHILD CHILD AND PARENT PARENT

How often are your child's teeth brushed?

_____

YES NO Is your home water supply fluoridated?
YES NO Is the water fluoridated where your child spends the day?
YES NO Does your child use a fluoride toothpaste?
YES NO Has your child had any other form of fluoride?

Has your child inherited any dental conditions? Please describe below:

_____

How are YOUR own teeth? (Cavities, braces…)_____

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

_____

If there is any information that you feel might be of value to us in the treatment of your child, please add it here:

_____

_____

Please read and initial the following statements:

_____I affirm that the information given above is correct to the best of my knowledge. It is my responsibility to inform Chapel Hill Pediatric Dentistry of any changes to my child's medical status.

_____I have the right to access the Notice of Privacy Practices at any time. The Notice of Privacy Practices provides a description of our treatment, payment activities, healthcare operations, and the uses/disclosures we may make of your protected health information.

_____I have understood the financial policy of Chapel Hill Pediatric Dentistry.

_____Your scheduled appointment has been reserved just for you. Obviously any change in this appointment affects another child who is waiting for a scheduled appointment. If you must cancel, we need to know at least 24 hours in advance. If 24 hour notice is not given, there will be a charge.

_____I request and authorize Dr. Rampersaud, and Associates of Chapel Hill Pediatric Dentistry to provide dental treatment for my child. I understand the dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age.

Yes No Do we have your permission to mail you a postcard reminding you to schedule your child's next recall appointment?

Because your child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before Dr. Rampersaud, and Associates can initiate and provide any dental treatment.

Signature _____Date ____/_____/_____

205 Sage Road, Suite 202 ▪ Chapel Hill, NC 27514 ▪ Phone (919) 929-0489 Fax (919) 933-3631

Patient(s) Name:_____

Insurance Information:

Insurance Name:_____

Dental Claims
Address:_____
_____
_____

Subscriber ID #:_____

Group Name and
Number:_____

Policy Holder's Information:

Name:_____

SS#_____

Date of birth:_____

Employer Name and
Address:_____
_____
_____
_____

Avni C. Rampersaud, D.D.S., P.A.
205 Sage Road, Suite 202
Chapel Hill, NC 27514
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Consent for Treatment of Minor Child

I, being the parent or guardian of _____ /_____
(Patient Name) (Date of Birth)
do hereby request and authorize Chapel Hill Pediatric Dentistry and Staff to perform necessary procedures for my child which are deemed advisable by the dentist, whether or not I am present at the actual appointment.

Below is a list of individuals who have my permission to bring my child in for treatment.

□ Patient by him/herself if age 18 years or older. □ I do not give permission

_____
_____
_____
_____
_____
_____

_____ _____
Signature of Parent of Guardian / Printed Name Date

_____ _____
Witness Date

Chapel Hill Pediatric Dentistry
Avni C. Rampersaud, D.D.S., P.A.
Diplomate, American Board of Pediatric Dentistry
205 Sage Road, Suite 202
Chapel Hill, NC 27514
(919)-929-0489

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name_____

Signature_____

Date_____

For Office Use Only:

We attempted to obtain written acknowledgment of receipt of our Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited us from obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)
- ☐ _____