Where the cool kids go.

CHILDREN'S DENTAL OF WALTHAM

General Dentistry for Kids

PATIENT INFORMATION

Today's Date: _____

Child's Name: FIRST _____ MIDDLE INITIAL _____ LAST _____

Child's Nickname: _____ ❒ Female ❒ Male

Child's Date of Birth: _____ Child's Age: _____

Telephone Numbers — Home: _____ Additional: _____

Email: _____

Home Address: _____
STREET CITY STATE ZIP

How did you hear about us? _____

Who is accompanying child today? _____ Relation to Child: _____
FULL NAME (if other than parent)

Do you have legal custody of this child? ❒ YES ❒ NO

Mother's Name: _____

Do you live with the child? ❒ YES ❒ NO

Address: _____
STREET CITY STATE ZIP

Telephone Numbers — Home: _____ Cell: _____ Additional: _____

Email: _____

Father's Name: _____

Do you live with the child? ❒ YES ❒ NO

Address: _____
STREET CITY STATE ZIP

Telephone Numbers — Home: _____ Cell: _____ Additional: _____

Email: _____

Initials

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please continue on back

DENTAL INFORMATION

Is the child in pain? ❒ YES ❒ NO How long? _____

Does the child require pre-medication? ❒ YES ❒ NO ❒ Don't know

Previous Dentist: _____ Telephone (____) _____

Last Dental Exam: _____ Last Dental X-rays: _____

How many times a day does child brush? _____ How many times a week does child floss? _____

Is the child's water fluoridated? ❒ YES ❒ NO ❒ Don't know

MEDICAL INFORMATION

Does the child have or ever had any of the following diseases, medical conditions or procedures? (Check all that apply)

- ❒ Heart Murmur
- ❒ Rheumatic fever
- ❒ Artificial Heart Valves
- ❒ Congenital Heart defect
- ❒ Scarlet Fever
- ❒ Surgeries/Operations
- ❒ Cancer/Tumors
- ❒ Chemotherapy
- ❒ Jaw Problems TMJ/TMD
- ❒ Hearing Problems
- ❒ Tonsilitis
- ❒ Respiratory Problems
- ❒ Asthma/Difficulty Breathing
- ❒ Blood Transfusion(s)
- ❒ Leukemia/Anemia
- ❒ Diabetes/Hypoglycemia
- ❒ Hemophilia
- ❒ Abnormal Bleeding
- ❒ Cleft Lip/Palate
- ❒ Birth Defects
- ❒ High/Low Blood Pressure
- ❒ Hepatitis
- ❒ Artificial Bones/Joints/Implants
- ❒ Liver/Kidney/Organ Problems
- ❒ HIV+/AIDS/ARC
- ❒ Tuberculosis TB
- ❒ Psychiatric Problems
- ❒ Hyper Active/ADD
- ❒ Fainting/Seizures/Epilepsy
- ❒ Cerebral Palsy

Please list any other medical condition(s) child has or ever had: _____

_____

Please list all medications your child is taking _____

Is child allergic to ❒ Latex ❒ Penicillin/Amoxicillin ❒ Tetracycline ❒ Dental Anesthetics (Novocaine) ❒ Aspirin

❒ Food Allergies ❒ Other(s): _____

Has this child ever taken the drug Ritalin? ❒ No ❒ Yes/How long? _____ Child's Blood type: _____

Does this child do any of the following? ❒ Thumb/Finger Sucking ❒ Tongue Thrusting/Sucking

❒ Heavy Snoring ❒ Mouth Breathing ❒ Lip Sucking/Biting

Reviewed by: _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date____/____/____

❒ Parent or Guardian ❒ Other: