Where the cool kids go.

CHILDREN'S DENTAL OF WALTHAM

General Dentistry for Kids

PATIENT INFORMATION

Today's Date: _____

Patient's Name: FIRST _____ MIDDLE INITIAL ____ LAST _____

Patient's Nickname: _____ ❒ Female ❒ Male

Date of Birth: _____ Patient's Age: _____

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

Email: _____

Home Address: _____
STREET CITY STATE ZIP

How did you hear about us? _____

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

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

Mother's Name: _____

Do you live with the patient? ❒ YES ❒ NO

Address: _____
STREET CITY STATE ZIP

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

Email: _____

Father's Name: _____

Do you live with the patient? ❒ 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

Are you in pain? ❒ YES ❒ NO How long? _____

Please indicate any of the following problems:

❒ Discomfort, clicking or popping in jaw
❒ Red, swollen or bleeding gums
❒ Sensitive tooth, teeth or gums
❒ Blisters/sores in or around the mouth
❒ Lost/Broken filling(s)
❒ Teeth grinding
❒ Ringing in ears
❒ Broken/chipped tooth
❒ Stained teeth
❒ Locking jaw
❒ Bad breath

Do you require pre-medication? ❒ YES ❒ NO ❒ Don't know

Previous Dentist: _____ Telephone (_____) _____

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

How many times a day do you brush? _____ How many times a week do you floss? _____

Is your 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) you have ever had: _____

_____

Please list all medications you are taking _____

Are you allergic to: ❒ Latex ❒ Penicillin/Amoxicillin ❒ Tetracycline ❒ Dental Anesthetics (Novocaine) ❒ Aspirin

❒ Food Allergies ❒ Other(s): _____

Do you use tobacco? ❒ No ❒ Yes/How used? _____ How much? _____ How long? _____

For women: Are you taking birth control pills? ❒ No ❒ Yes How many children have you had? _____

Are you pregnant? ❒ No ❒ Yes/How far along are you? _____ Are you nursing? ❒ No ❒ Yes

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: