Pediatric Dentistry

For office use
Reviewed by: _____
Date: _____

Patient Registration and Health History

Child's Name _____ Sex ___ Date of Birth _____ Nickname _____

Name and age of siblings _____

Child's hobbies and special interests _____

Pets (type and name) _____

Street Address _____ Phone _____

City _____ State _____ Zip _____ Email _____

Who may we thank for referring you? _____

Pediatrician _____ City _____ Phone _____

Previous Dentist _____ City _____ Phone _____

Parent's Name _____ Mobile # _____

Employed by _____ Present Position _____

Parent's Name _____ Mobile # _____

Employed by _____ Present Position _____

PRIMARY DENTAL INSURANCE

* I authorize any provider to release any information regarding the dental history, treatment or benefits payable for treatment to any authorized agent for purposes of determining benefits payable. I authorize payment directly to dentist for services rendered.

SIGNATURE _____

Subscriber Name _____ Date of Birth _____ SS# _____

Employer Name _____ Address _____

Insurance Company _____ Effective Date _____ Phone _____

Address _____

Subscriber # _____ Group # (if applicable) _____

Medical Insurance Plan _____

SECONDARY DENTAL INSURANCE

* I authorize any provider to release any information regarding the dental history, treatment or benefits payable for treatment to any authorized agent for purposes of determining benefits payable. I authorize payment directly to dentist for services rendered.

SIGNATURE _____

Subscriber Name _____ Date of Birth _____ SS# _____

Employer Name _____ Address _____

Insurance Company _____ Effective Date _____ Phone _____

Address _____

Subscriber # _____ Group # (if applicable) _____

Medical Insurance Plan _____

MEDICAL HISTORY

Has your child been seen by a physician during the last 12 months ☐ YES ☐ NO

Is your child under medical care at present? If so, for what reason? ☐ YES ☐ NO

Does your child have any possible or confirmed allergies? ☐ YES ☐ NO

Medication _____ Food _____ Other _____

Is your child taking any medication now? ☐ YES ☐ NO

What medication? _____ Why? _____

Has your child ever been hospitalized? ☐ YES ☐ NO

When? _____ Why? _____

Has your child had any operations? ☐ YES ☐ NO

When? _____ Why? _____

Has general anesthetic ever been administered to your child? ☐ YES ☐ NO

Any complications? Please describe _____ ☐ YES ☐ NO

Does your child bruise easily? ☐ YES ☐ NO

Has your child ever bled excessively from a cut or injury? ☐ YES ☐ NO

Has your child had any of the following? (Check all that apply)

☐ Heart disease ☐ Liver disease ☐ Diabetes ☐ Rheumatic fever ☐ Kidney disease

☐ Seizures ☐ Heart murmur ☐ Hepatitis ☐ Anemia ☐ Asthma

☐ HIV ☐ Learning disabilities ☐ Emotional disabilities ☐ Hearing or Speech difficulties

Please describe _____

How does your child accept his/her pediatrician? _____

DENTAL HISTORY

Is this your child's first visit to the dentist? If no, date of last visit _____ ☐ YES ☐ NO

Procedures done _____ Child's reaction _____

Have dental radiographs been taken? When? _____ ☐ YES ☐ NO

Reason for this visit _____

Describe your child's temperament and probable reaction to dental treatment _____

_____

How often are your child's teeth brushed? _____ Do you help brush? ☐ YES ☐ NO

How often is floss used? _____ Do you help floss? ☐ YES ☐ NO

Is your drinking water fluoridated? ☐ YES ☐ NO

If not, does your child receive fluoride supplements? ☐ YES ☐ NO

Did your child ever take a bottle or sippy cup to bed? ☐ YES ☐ NO

Does your child have any habits which might affect the mouth or teeth? (Check all that apply)

☐ Breathes through mouth ☐ Tongue thrust/habit ☐ Sucks thumb or fingers

☐ Pacifier If yes, until what age? _____

Please describe the parent's history of dental decay: high, average, or low

Mother _____ Father _____

SIGNATURE _____ Date _____

Relationship to patient _____

Please fill out the form, print the form and bring it with you to the appointment.

If you don't have a printer, call us and we will send you one.

290 Baker Avenue | Concord, MA 01742 | 978.369.7771

219 Boston Post Road West | Marlboro, MA 01752 | 508.481.8161