We are pleased to welcome you and your child to our practice. Please take a few moments to fill out this form as completely as you can. We look forward to working with you to care for your child's dental health.

PATIENT INFORMATION

Patient _____ Date _____

Nickname _____ DOB _____ Age _____ Sex ☐ F ☐ M

School _____ Grade _____

Home Address _____

Home Phone _____ E-mail _____

Names and ages of other children in family _____

Guardian #1 _____ Relationship _____ Cell Phone _____

Employer _____ Work Phone _____

Social Security # _____ Date of Birth _____

Guardian #2 _____ Relationship _____ Cell Phone _____

Employer _____ Work Phone _____

Social Security # _____ Date of Birth _____

Who has legal custody of patient? _____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Subscriber Name: _____ SS#: _____ D.O.B. _____

Employer Name: _____

Employer Address: _____

Insurance Company: _____ Phone #: _____

Insurance Address: _____

Subscriber#: _____ Group# (if applicable): _____

SECONDARY DENTAL INSURANCE

Subscriber Name: _____ SS#: _____ D.O.B. _____

Employer Name: _____

Employer Address: _____

Insurance Company: _____ Phone #: _____

Insurance Address: _____

Subscriber#: _____ Group# (if applicable): _____

I authorize my provider to release information regarding dental treatment to my insurance company for payment directly to the dentist for services rendered. I understand I will be responsible for all co-payments, deductibles, and rejected charges.

Signature: _____ Date: _____

137 West Main Street Northborough, MA 01532
508-393-9394 www.mychildrensdentist.com
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HEALTH HISTORY

Name of child's physician_____ Phone Number_____

Location of child's physician_____ Date of last physical exam_____

☐ Yes ☐ No Are your child's immunizations up to date?_____

☐ Yes ☐ No Has your child ever had a health problem?_____

☐ Yes ☐ No Is your child currently taking any medications? Name_____

Doses and reason _____

☐ Yes ☐ No Is your child allergic to anything?_____

☐ Yes ☐ No Has your child ever been hospitalized? Please give reason and dates_____

☐ Yes ☐ No Has your child had any operations? _____

☐ Yes ☐ No Has your child had general anesthesia? Any complications?_____

☐ Yes ☐ No Were there any problems at birth?_____

☐ Yes ☐ No Does your child have sensory issues? If yes, to what? _____

Was your child: ☐ Breast fed ☐ Bottle fed At what age was it stopped?_____

Please check if your child has been treated for any of the following:

☐ Heart disease	☐ Bleeding/transfusions/Anemia	☐ Cleft lip/palate	☐ Speech/hearing
☐ Liver disease/ Hepatitis	☐ Asthma	☐ Congenital birth defects	☐ Spectrum/Autism
☐ Kidney disease	☐ Rheumatic fever	☐ HIV/AIDS	☐ Mental delays
☐ Gastrointestinal disease	☐ Seizures	☐ Frequent infections	☐ Anxiety Problems
☐ Cerebral palsy	☐ Diabetes	☐ Physical delays	☐ ADHD
☐ Cancer/tumors	☐ Recurrent headaches	☐ Blood disorder	☐ Other _____

Comments: _____

_____

DENTAL HISTORY

☐ Yes ☐ No Has your child ever been to the dentist? Name of dentist_____

Date of Last Dental Visit? _____ Date of Last X-rays? _____

☐ Yes ☐ No Do you think your child will react well to dental treatment? Explain_____

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier? Ages when: _____

☐ Yes ☐ No Does your child brush daily? How often? Do you help?_____

☐ Yes ☐ No Do your child's teeth get flossed daily? _____

☐ Yes ☐ No Does your child have snacks between meals? Preferred snacks _____

☐ Yes ☐ No Have your child's teeth ever been injured? When? _____ Treatment? _____

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Toothache	☐ Sensitive teeth
☐ Surgical Mouth Treatment	☐ Gum Infections	☐ Discolored teeth
☐ Orthodontics	☐ Jaw Sounds/Pain	☐ Grinding

Comments: _____

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FLUORIDE HISTORY

☐ Yes ☐ No Is your home water supply fluoridated? _____

☐ Yes ☐ No Is your child's school water supply fluoridated? _____

☐ Yes ☐ No Does your child use a fluoride toothpaste? Kind? _____

☐ Yes ☐ No Does your child use a fluoride supplement? *Dose*: ☐ 0.25 mg ☐ 0.50 mg ☐ 1.00 mg

☐ Yes ☐ No Do you give your child any other forms of fluoride? What? _____

Amount? _____

CONSENT FOR DENTAL TREATMENT

You have a right to accept or reject dental treatment. Prior to consenting you should consider the benefits and risks of the procedure, alternative treatments or the option of no treatment. Do not consent unless all of your questions have been answered and you have acknowledged your willingness to accept known risks and complications no matter how slight the risks. Small risks may include swallowing or inhaling of saliva or dental materials, discomfort, bleeding, post numbing bite trauma, bruising, swelling, or numbness. I understand that drugs and medications including antibiotics, analgesics and other medicines can cause allergic reactions causing redness, swelling of tissues, pain, vomiting or anaphylactic shock (severe allergic reaction). The dentists (Dr. Jolanta Macdonald, Dr. Craig Macdonald, and Dr. Anita Bhatt) at Children's Dentistry of Northborough do everything possible to minimize or completely prevent these risks and side effects. By signing this consent you are allowing any of these dentists to diagnose and treat your child.

I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. The staff at Children's Dentistry of Northborough will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

I consent for my child to receive cleanings, dentist examinations, fluoride treatment, photographs, and x-rays. Should I agree to a treatment plan, I consent to allow the providers of this office to do sealants, fillings and other common procedures within the standards of care for the duration of my time as a patient at Children's Dentistry of Northborough. If I wish not to consent to any of the above I agree to inform the dentist the day of my appointment.

Signature _____ Date _____

OTHER INFORMATION I WOULD LIKE MY CHILD'S DENTIST TO KNOW

_____

_____

_____

_____

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