

The Dental Place  
 24 Lyman Street • Suite 240  
 Westborough, MA 01581  
 (508) 366-0122

Date of Record \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Reviewed by \_\_\_\_\_

### PATIENT INFORMATION

**PERSONAL**

PATIENT'S NAME (Last)	(First)	(Nickname)	<input type="checkbox"/> Male <input type="checkbox"/> Female	BIRTH DATE
PRESENT ADDRESS (Street)	(City)	(State)	(Zip)	HOME TELEPHONE
FATHER'S NAME	BIRTHDATE	SOCIAL SECURITY #	OCCUPATION / EMPLOYER	
MOTHER'S NAME	BIRTHDATE	SOCIAL SECURITY #	OCCUPATION / EMPLOYER	
AGE and NAME OF SIBLINGS				

**PARENT'S INFORMATION**

Single   
  Married   
  Separated   
  Divorced   
  Widowed

MOTHER'S WORK #	MOTHER'S CELL #
FATHER'S WORK #	FATHER'S CELL #
CHILD'S PHYSICIAN	TELEPHONE #
PREVIOUS or FAMILY DENTIST	TELEPHONE #
WHOM CAN WE THANK FOR REFERRING YOU?	
ADDRESS	

### MEDICAL HISTORY

1. Were there any difficulties during the pregnancy, delivery or first year of the child's life?  No     Yes  
     If so, what? \_\_\_\_\_
2. Was your child premature?  No     Yes
3. Is a physician treating your child now for a specific illness?  No     Yes  
     If so, for what reason? \_\_\_\_\_
4. Is your child taking any medication at this time?  No     Yes

DRUG	DOSE	FREQUENCY	REASON

5. Has your child taken any unusual medications in the past?  No  Yes  
If so, what? \_\_\_\_\_ For what reason? \_\_\_\_\_
6. Has your child shown any allergies or unusual reactions?  No  Yes  
a. Medications or drugs \_\_\_\_\_  
b. Foods \_\_\_\_\_  
c. Latex \_\_\_\_\_  
d. Other \_\_\_\_\_
7. Has your child ever been hospitalized?  No  Yes  
If so, when & for what reason? \_\_\_\_\_
8. Has your child had any operations?  No  Yes  
If so, when & for what reason? \_\_\_\_\_  
Was general anesthesia used?  No  Yes  
Any complications, if so, what? \_\_\_\_\_
9. Are your child's immunizations up to date?  No  Yes
10. Does your child have any history of the following diseases / conditions?  No  Yes  
(Check applicable box)
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Rheumatic fever                                | <input type="checkbox"/> Hepatitis        | <input type="checkbox"/> Sickle Cell Disease or Trait |
| <input type="checkbox"/> Heart Disease                                  | <input type="checkbox"/> Tuberculosis     | <input type="checkbox"/> Cystic Fibrosis              |
| <input type="checkbox"/> Jaundice                                       | <input type="checkbox"/> Bleeding Problem | <input type="checkbox"/> Leukemia or Tumors           |
| <input type="checkbox"/> Diabetes                                       | <input type="checkbox"/> Seizures         | <input type="checkbox"/> Kidney Disease               |
| <input type="checkbox"/> Asthma   | <input type="checkbox"/> Anemia           | <input type="checkbox"/> Cerebral Palsy               |
| <input type="checkbox"/> Liver Disease                                  | <input type="checkbox"/> Child Abuse      | <input type="checkbox"/> AIDS                         |
| <input type="checkbox"/> Heart Murmur, Type? _____                      |   |   |
| <input type="checkbox"/> Learning Disabilities, Type? _____             |   |   |
| <input type="checkbox"/> Emotional Disabilities, Type? _____            |   |   |
| <input type="checkbox"/> Hearing Difficulty, Type? _____                |   |   |
| <input type="checkbox"/> Speech Difficulty, Type? _____                 |   |   |
| <input type="checkbox"/> Developmental Disability or Delay, Type? _____ |   |   |
11. Does your child bruise easily?  No  Yes
12. Has there ever been any history of spontaneous bleeding (e.g. nose bleeds) or prolonged bleeding following tooth removal, surgery, cuts, etc.?  No  Yes

Remarks: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### DENTAL HEALTH HISTORY

1. Please check reason(s) for seeking dental care:
- |  |  |  |
|--|--|--|
| <input type="checkbox"/> 1st Exam            | <input type="checkbox"/> Routine Check-Up  | <input type="checkbox"/> Toothache or Swelling |
| <input type="checkbox"/> Appearance of Teeth | <input type="checkbox"/> Crowding of Teeth | <input type="checkbox"/> Accident              |
| <input type="checkbox"/> Other _____         |  |  |

2. Has your child been to a dentist previously?  No  Yes  
 a. If so, when was the last visit? \_\_\_\_\_  
 b. Have x-rays been taken & when? \_\_\_\_\_
3. How do you think your child will react to dental treatment? \_\_\_\_\_
4. Has your child had fluoride in any of the following forms?  
 Fluoride tablets or in vitamins (Fluoride amt. .25 .5 1.0 mg)  No  Yes  
 Drinking water (community fluoridation)  No  Yes
5. Have your child's teeth ever been injured?  No  Yes  
 When? \_\_\_\_\_ Which Teeth? \_\_\_\_\_ Cause? \_\_\_\_\_  
 Were the teeth treated?  No  Yes  
 If so, what? \_\_\_\_\_
6. Does your child have any of the following habits?  Bottle to Bed at Night  
 Thumb or Finger Sucking  Pacifier  
 Lip Sucking or Biting  Breaths through Mouth  
 Other \_\_\_\_\_

*I hereby give permission to The Dental Place to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not be limited to, topical and local anesthetic (injections), voice control, radiographs (x-rays).*

Signature of Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_

### INSURANCE INFORMATION

NAME OF POLICY HOLDER	SOCIAL SECURITY #
NAME OF EMPLOYER	GROUP #
NAME OF INSURANCE COMPANY	
ADDRESS (INSURANCE CO.)	TEL. # (INSURANCE CO.)

**YOUR INSURANCE MAY ONLY PARTIALLY COVER SERVICES PROVIDED. COVERAGE VARIES AMONG INSURANCE COMPANIES AND EVEN AMONG EMPLOYERS. THE PARENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. BECAUSE OF THE DIFFICULTY IN BILLING A THIRD PARTY, THE PARENT WHO BRINGS THE CHILD FOR HIS/HER CARE WILL BE FINANCIALLY RESPONSIBLE FOR ALL TREATMENT FEES. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.**

*I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE DENTAL PLACE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I ACKNOWLEDGE RECEIPT OF THE PRIVACY POLICY FOR THE DENTAL PLACE.*

X \_\_\_\_\_

Date \_\_\_\_\_

*This office reserves the right to verify credit status of patients seeking payment terms.*

