Dental Place Hopkinton
79 Hayden Rowe Street
Hopkinton, MA 01748
(508) 435-5437

Date of Record ____/____/____
Reviewed by _____

PATIENT INFORMATION

PATIENT'S NAME (Last)	(First)	(Nickname)	❒ Male ❒ Female	BIRTHDATE

PRESENT ADDRESS (Street) (City) (State) (Zip)

MOTHER'S NAME	DOB	OCCUPATION / EMPLOYER	CELL #	❒ Preferred #
FATHER'S NAME	DOB	OCCUPATION / EMPLOYER	CELL #	❒ Preferred #

FAMILY E-MAIL ADDRESS | HOME PHONE # ❒ Preferred #

NAME and AGE OF SIBLINGS

CHILD'S PHYSICIAN (Practice Name and Doctor's Name) (City) (State) TELEPHONE #

PREVIOUS or FAMILY DENTIST (City) (State) TELEPHONE #

HOW DID YOU HEAR ABOUT US?

❒ FRIEND and/or FAMILY MEMBER: _____ ❒ PHYSICIAN: _____

❒ SCHOOL VISIT ❒ INTERNET SEARCH ❒ INSURANCE CO. ❒ OTHER: _____

MEDICAL HISTORY

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

Drug	Dose	Frequency	Reason

5. Has your child shown any allergies or unusual reactions? ❒ No ❒ Yes
   ❒ Latex ❒ Medication or drugs ❒ Foods ❒ Other
   Please list specific allergens: _____
   Is an Epi-Pen required? ❒ No ❒ Yes
6. Has your child ever been hospitalized? ❒ No ❒ Yes
   If yes, when? _____ For what reason? _____
7. Has your child had any operations? ❒ No ❒ Yes
   If yes, when? _____ For what reason? _____
   Was general anesthesia used? ❒ No ❒ Yes
   If yes, were there any complications? ❒ No ❒ Yes _____
8. Are your child's immunizations up to date? ❒ No ❒ Yes
9. Does your child bruise easily? ❒ No ❒ Yes
10. Has there ever been any history of spontaneous bleeding (e.g. nose bleeds) or prolonged bleeding following tooth removal, surgery, cuts, etc.? ❒ No ❒ Yes

11. Does your child have a history of the following diseases / conditions? ..... ❒ No ❒ Yes

❒ Rheumatic Fever ❒ Hepatitis ❒ Sickle Cell Disease or Trait ❒ AIDS

❒ Heart Disease ❒ Tuberculosis ❒ Cystic Fibrosis ❒ Jaundice

❒ Bleeding Problem ❒ Leukemia or Tumors ❒ Diabetes ❒ Asthma

❒ Seizures ❒ Kidney Disease ❒ Anemia ❒ Liver Disease

❒ Cerebral Palsy ❒ Child Abuse ❒ Heart murmur: Type? _____

❒ Emotional disabilities ❒ Hearing difficulty ❒ Speech difficulty ❒ Learning disability

❒ Developmental disability or delay

Type of disability, delay, or difficulty _____

12. Have you ever been told that your child requires pre-medication prior to dental treatment? ..... ❒ No ❒ Yes

DENTAL HEALTH HISTORY

1. Please check reason(s) for seeking dental care:

❒ First Exam ❒ Routine Check-Up ❒ Toothache or Swelling ❒ Accident

❒ Appearance of Teeth ❒ Crowding of Teeth ❒ Other _____

2. Has your child been to a dentist previously? ..... ❒ No ❒ Yes

If so, when was the last visit? _____

Have x-rays been taken? ❒ No ❒ Yes, date _____

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 vitamins Dosage: ❒ 0.25mg ❒ 0.5mg ❒ 1.0mg

❒ Drinking water (community fluoridation)

5. Have your child's teeth ever been injured? ..... ❒ No ❒ Yes

If yes, when? _____ Which teeth? _____ Cause? _____

Treatment, if any _____

6. Does your child have any of the following habits?

❒ Thumb or Finger Sucking ❒ Bottle to Bed at Night ❒ Breathes through Mouth

❒ Lip Sucking or Biting ❒ Pacifier ❒ Other _____

I hereby give permission to 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, and radiographs (x-rays). I consent to Dental Place contacting my cell phone regarding treatment, appointments, or my account.

Signature of Legal Guardian ✘ _____ Date _____

INSURANCE INFORMATION

NAME of POLICY HOLDER	BIRTHDATE of POLICY HOLDER	SUBSCRIBER ID #
EMPLOYER	INSURANCE COMPANY	GROUP #
INSURANCE COMPANY ADDRESS		INSURANCE COMPANY TELEPHONE #

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 Dental Place of the group insurance benefits otherwise payable to me. I acknowledge receipt of the privacy policy for Dental Place.

✘ _____ Date _____

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