DENTAL HEALTH HISTORY

1. Please check reason(s) for seeking dental care
   - ❒ First Examination
   - ❒ Routine check-up
   - ❒ Toothache or swelling
   - ❒ Appearance of teeth
   - ❒ Crowding of teeth
   - ❒ Accident
   - ❒ Other ________________________________

2. If your child has been to a dentist previously?________________________ ___Yes ___No
   a. When was the last visit?________________________
   b. Have x-rays been taken and when?________________________
   c. How would you describe your child's dental treatment?________________________

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**) (Please Circle) ___Yes ___No
   Drinking water (community fluoridation) ___Yes ___No
   Topical applications to teeth; date of last ________________________
   Toothpaste; brand ________________________
   Fluoride rinse/gel: brand________________________

5. Does your child brush his / her own teeth? ___Yes ___No
   How frequently and when? ___AM ___PM ___ After Snacks ___Before Bed ___ After Breakfast

6. Do you brush your child's teeth? ___Yes ___No
   How frequently and when? ___AM ___PM ___ After Snacks ___Before Bed ___ After Breakfast

7. Do you or your child use dental floss in cleaning your child's teeth? ___Yes ___No
   How frequently and when? ___AM ___PM ___ After Snacks ___Before Bed ___ After Breakfast

8. Does your child have between meal snacks? ___Yes ___No

9. Have your child's teeth ever been injured? ___Yes ___No
   When?____________Which Teeth?____________ Cause?____________
   Were the teeth treated? ___Yes ___No
   If so describe treatment________________________

10. Does your child have any of the following habits?
    - ❒ Bottle to bed at night
    - ❒ Thumb or finger sucking
    - ❒ Pacifier
    - ❒ Lip sucking or biting
    - ❒ Breathes through mouth
    - ❒ Other ________________________

11. Has your child received any unusual dental or surgical treatment to the mouth? ___Yes ___No
    If so, what?________________________

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

Signature of Legal Guardian ________________________ **Date**____________

MEDICAL HISTORY

1. Were there any difficulties during the pregnancy, delivery or first year of the child's life? ____Yes____No
2. Was your child premature? ____Yes____No
3. Is a physician treating your child now for a specific illness? ____Yes____No
   If so, for what reason? ____________________
4. Is your child taking any medication at this time? ____Yes____No

Drug **Dose** **Frequency**

Reason

5. Has your child taken any unusual medications in the past ____Yes____No
   If so, what?____________________ For what reason? ____________________
6. Has your child shown any allergies or unusual reactions? ____Yes____No
   a. Medications or drugs____________________
   b. Foods ____________________
   c. Latex ____________________
   d. Other ____________________
7. Has your child ever been hospitalized? ____Yes____No
   If so, when?____________________
   For what reason?____________________
8. Has your child had any operations? ____Yes____No
   For what reason? ____________________
   Was general anesthesia used? ____Yes____No
   Any complications, if so, what? ____________________
9. Are your child's immunizations up to date? ____________________
10. Does your child have any history of the following diseases or conditions? (if "yes" check off boxes that apply)

❒ Rheumatic fever ❒ Hepatitis ❒ Sickle Cell Disease or Trait
❒ Heart Disease ❒ Tuberculosis ❒ Cystic Fibrosis
❒ Jaundice ❒ Bleeding Problem ❒ Leukemia or Tumors
❒ Diabetes ❒ Seizures ❒ Kidney Disease
❒ Asthma ❒ Anemia ❒ Cerebral Palsy
❒ Liver Disease ❒ Child Abuse ❒ AIDS

❒ Heart Murmur, Type?____________________
❒ Learning Disabilities, Type?____________________
❒ Emotional Disabilities, Type?____________________
❒ Hearing Difficulty, Type?____________________
❒ Speech Difficulty, Type?____________________
❒ Developmental Disability or Delay, Type?____________________

11. Does your child bruise easily? ____Yes____No
12. Does your child receive any special services or have they been recommended? ____Yes____No

____

13. Is there any tobacco use in the child's home? ____Yes____No
14. Has there ever been any history of spontaneous bleeding (e.g. nose bleeds) or prolong bleeding following tooth removal surgery, cuts, etc.? ____Yes____No

Remarks:____________________

____

____

pediatric dental associates of brookline, p.c.

1684 Beacon Street
Brookline, MA 02445
tel: 617 232 7100
fax: 617 232 4191

DATE OF RECORD____/____/____
REVIEWED BY:________________

PATIENT INFORMATION

PERSONAL

Patient's Last Name ____ First Name ____ M.I. ____ Home Telephone ____ Birthdate ____

Nickname ____ Sex ____ Street Address ____ Town ____ Zip ____

Previous Address if < 1 yr. at Current Address ____ Town ____ State ____ Zip ____

Age and Name of Siblings________________

PARENT'S INFORMATION

____ Single ____ Separated ____ Married ____ Divorced ____ Widowed

Parent #1 Name ____ Birthdate ____ Social Security # ____ Employer ____

Parent #2 Name ____ Birthdate ____ Social Security # ____ Employer ____

Parent #1 Work # ____ Parent #1 Cell Phone # ____ Parent #1 E-mail Address ____

Parent #2 Work # ____ Parent #2 Cell Phone # ____ Parent #2 E-mail Address ____

Previous or Family Dentist ____ Telephone ____

Child's Physician ____ Telephone ____

Whom can we thank for referring you? ________________

Address ________________

INSURANCE INFORMATION

NAME OF POLICY HOLDER	GROUP NUMBER	SOCIAL SECURITY #
NAME OF EMPLOYER	EFFECTIVE DATE	
NAME OF DENTAL INSURANCE COMPANY		
SECONDARY COVERAGE (DENTAL)		

YOUR DENTAL INSURANCE MAY ONLY PARTIALLY COVER SERVICES PROVIDED. COVERAGE VARIES AMONG INSURANCE COMPANIES AND EVEN AMONG EMPLOYERS. WE WILL SUBMIT CLAIMS TO YOUR PRIMARY INSURANCE CARRIER ONLY (UNLESS YOUR SECONDARY CARRIER IS DELTA DENTAL OF MA OR BC/BS). A PARENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. BECAUSE OF THE DIFFICULTY IN BILLING TO 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.

I HEREBY AUTHORIZE PAYMENT TO PEDIATRIC DENTAL ASSOCIATES OF BROOKLINE OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

X________________________

Signed (insured person)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of Pediatric Dental Associates of Brookline, P.C. notice of Privacy Practices.

Print Name ____________________

Signature ____________________

Date ____________________ ❐ Patient signature refused

RE-EVALUATION OF ORIGINAL PATIENT INFORMATION FORM

DATE	NO CHANGE	CHANGES	PARENT'S INITIALS