Dr. AnnaMarie DeFeo
82 Forest Street
Medford, MA 02155
(781) 396-1980

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 DR. ANNAMARIE DEFEO OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

X _____
Signed (insured person)

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:_____

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?

❒ Thumb or finger sucking ❒ Bottle to bed at night

❒ Lip sucking or biting ❒ Pacifier

❒ Other _____ ❒ Breathes through mouth

11. Has your child received any unusual dental or surgical treatment to the mouth? ___Yes ___No

If so, what? _____

I hereby give permission to Dr. AnnaMarie DeFeo 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** _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I have received a copy of Dr. AnnaMarie Defeo 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