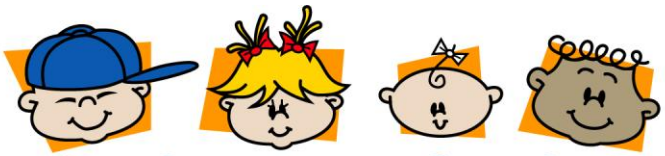

Pediatric Dental Healthcare

Specialists in Pediatric Dentistry and Orthodontics

Date: **Patient Registration** **Please Print**

Patient's Name _____ Nickname _____ Birth date _____ Sex _____

Patient's Address _____ Contact Phone # _____
street city state zip

Other electronic forms of communication are used in our office. Should you wish to take advantage of these; please read and fill out the area provided.

Father's Name _____ DOB_____ Mother's Name _____ DOB _____

Parent's Marital Status _____ Address (if different than above) _____

Father's Employer _____ Social Security # _____ Business Phone _____

Mother's Employer _____ Social Security # _____ Business Phone _____

For Patient's Covered By Insurance

Subscriber's Name _____ Birth Date _____ Social Security # _____

Subscriber's Employer _____ Business Address _____

Name of Ins. Co. You Mail Forms To _____

Group # _____ Subscriber ID # _____

Secondary Insurance

Subscriber's Name _____ Birth Date _____ Social Security # _____

Subscriber's Employer _____ Business Address _____

Name of Ins. Co. You Mail Forms To _____

Group # _____ Subscriber ID # _____

Dental History

Date of last visit to a dentist _____

For what service (cleaning, emergency visit, filling) _____

_____

Date of last dental x-rays _____

	Yes	No
Has child complained about dental problems, explain _____	☐	☐
Any unhappy dental experiences, explain _____	☐	☐
Any dental habits – thumb sucking, pacifier, etc. _____	☐	☐

	Yes	No
Does your child brush teeth daily _____	☐	☐
Do you assist child with tooth brushing _____	☐	☐
Is dental floss used/how often _____	☐	☐
Does your child take any fluoride supplementation _____	☐	☐
Orthodontic appliances, worn now or ever been _____	☐	☐
Any injuries to mouth – teeth – head _____	☐	☐

Child's attitude towards dentistry _____

16 Washington Street (Rt.1) Plainville, MA 02762
www.PediatricDentalHealthcare.com 508.695.2064 www.BracesForKids.com

Health History

Child's Physician _____ Address _____ Phone _____

Is your child currently under care of a physician/doctor/ dentist? explain _____ Yes ☐ No ☐

Is your child receiving any medications or drugs (vitamins, prescriptions, etc.) _____ Yes ☐ No ☐

Is there any excessive bleeding when cut _____ Yes ☐ No ☐

Does your child have any allergies to drugs/antibiotics, latex, dyes, other? explain _____ Yes ☐ No ☐

Is your child currently under the care of a psychiatrist/ psychologist for any mental or emotional issues? explain _____ Yes ☐ No ☐

Has child ever been hospitalized, explain _____ Yes ☐ No ☐

Has child ever had surgery, explain _____ Yes ☐ No ☐

Has Child Had Any History Of Or Difficulty With Any Of The Following:

___ Anemia ___ Asthma ___ Blood/Bleeding Disorders ___ Bone/Joint Replacement ___ Cancer

___ Cerebral Palsy ___ Chronic Sinus ___ Convulsions ___ Diabetes ___ Ear Aches/Infections ___ Epilepsy/Seizures

___ Fainting ___ Hearing ___ Heart ___ Hepatitis ___ HIV/AIDS ___ Kidney

___ Liver ___ Mastoid ___ Mononucleosis ___ Pregnancy (teen) ___ Rheumatic Fever ___ Thyroid

___ Tobacco Use ___ Tuberculosis ___ OTHER: _____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed. _____

May we request release of your child's medical records for our reference _____ Yes ☐ No ☐

In an effort to improve communications with our patients, Pediatric Dental Healthcare will be E-mailing and/or texting appointment reminders. If you are interested in being part of this service, please enter your information below. Please be aware that this email address may also be used to email you personal information (ie.Receipts,Invoices,Letters) relating to your dental care. Your information is only used for communications with you and other dental professionals. We do NOT share or sell personal information.

Personal E-mail: _____ Mobile Phone#: _____

(Please Print Clearly) (Your Phone Provider May Charge a Texting Fee)

I hereby authorize the dentists and staff at Pediatric Dental Healthcare to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. (*Please cross out any treatment that you do not want performed.*) I authorize my insurance company to pay Pediatric Dental Healthcare all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment services charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Pediatric Dental Healthcare. This consent is to remain in effect from the date indicated until cancelled in writing.

Authorized Signature _____

Relationship to Child Date