Patient (Your Child's) Information

First Name _____ Last Name _____ Date of Birth_____ Child's Social Security #_____

Address_____ City_____ State _____ Zip_____

Legal Guardian Information

First Name _____ Last Name _____ Date of Birth_____ Relationship: Mom / Dad / Other

Social Security # _____ Employer _____ Is the legal guardian here with the child today? Y / N

The office uses an automated system to confirm appointments. Please provide a working cellular phone number and an email address in which you frequently check. Cell Phone #_____ Email _____

Emergency Contact Information: First Name _____ Last Name _____ Phone #_____

How did you hear about our office? Google - Facebook/Instagram – 93S Billboard - Lowell Conn Billboard – Friend - Insurance - Pediatrician

Another Dentist _____ Other(Please Specify) _____

DENTAL INSURANCE

If your child has MassHealth or NH Medicaid what is the # on the card: MassHealth # 100_____ , NH Medicaid #_____

If your child is covered under a parent's Dental Insurance Policy what is the Insurance Name:_____

Policy Holder Name _____ Policy Holder Date of Birth _____Policy Holder Social Security #_____

MEDICAL HISTORY Primary physician:_____ Medications: _____ Allergies : _____

Does your child have any Heart/ Neurological/ Endocrine / Lung/ Blood / or Immune Disorders? Yes / No _____

Does your child have Autism / ADHD / Seizures / Asthma/ Brain Shunt / Acid Reflux / Snoring? Yes / No _____

Does your child have HIV(AIDS) / Hepatitis, or any other communicable diseases? Yes / No _____

Is your child pregnant? Yes / No

Is there anything special you would like us to know?_____

DENTAL HISTORY

Do you have concerns about your child's dental health today? _____

How often does your child brush and floss? _____ Does someone help? YES / NO What toothpaste is used? _____

How often does your child have: Candy, Juice, Soda: Never / Sometimes /Always _____

Does your child suck their Thumb or use a Pacifier? YES / NO. How Often?_____

Does your child sleep with a bottle or use a sippy cup ? YES / NO . If YES, what is in it? _____

Who is your child's primary care taker during the day? _____

Please read the following carefully and sign at the bottom

Notice of Privacy Practices: I have received this office's Notice of Privacy Practices and understand protected health information will be used to conduct normal operations.

Treatment Consent: Treatment provided for routine checkup and new patient appointments may include the following: exam, cleaning, fluoride treatment, and x-rays as deemed necessary by the doctor. If for any reason you would not like us to perform these services, then you must inform us before your child's appointment begins.

Financial Consent: It is your responsibility to provide us with accurate, and complete insurance information for your child. If payment is denied by your insurance company, we will notify you and may ask you to assist us in contacting your insurance company. If payment is not made by your insurance company then you will be financially responsible for your child's account balance.

Signature of Legal Guardian _____ Date _____