West Roxbury Smiles
Pediatric Dentistry • Orthodontics

PEDIATRIC PATIENT HISTORY

Thank you for selecting our dental team! To help us meet all your health/dental needs, please fully complete this form in ink. If you have any questions, concerns or need assistance, please ask us and we will be happy to help.

Patient's Medical Health

Patient's full name First name Middle Last Name ______ Date of Birth / / ______

Pediatrician's name ______ City ______ Office ( ) ______

Date of last full physical exam / / ______ Is your child under medical care now? ☐ Yes ☐ No

If 'yes', please explain: ______

Has your child been hospitalized within the last five (5) years? ☐ Yes ☐ No If 'yes', please explain

______

Is your child taking any medications or prescriptions at this time? ☐ Yes ☐ No

If 'yes', please list: ______

Does your child take vitamins or supplements on a regular basis? ☐ Yes ☐ No

If 'yes', please list: ______

How is your child's general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

How much fluoridated water does your child drink daily? ☐ 2-4 cups ☐ 5-8 cups

What does your child drink besides water? ______

Does your child drink any diet soda or any beverages containing artificial sweeteners? ☐ Yes ☐ No

Does your child smoke or use tobacco of any kind? ☐ Yes ☐ No

Allergies

☐ Local anesthetics (Novocain) ☐ Iodine ☐ Aspirin ☐ Penicillin
☐ Tylenol liquid containing red dye) ☐ Any metals (nickel, mercury, etc.) ☐ Latex products
☐ Sulfa drugs ☐ Other ______

Does your child have (or ever had) any of the following:

☐ Heart murmur
☐ Mitral valve prolapse
☐ Diabetes
☐ Asthma
☐ Epilepsy/Convulsions
☐ Headaches/migraines
☐ Stomach troubles
☐ Blood disorders
☐ AIDS or HIV
☐ Cerebral damage
☐ Down's syndrome
☐ High blood pressure
☐ Heart condition of any kind
☐ Seasonal allergies
☐ Tuberculosis
☐ Neurological problems
☐ Hepatitis/jaundice
☐ Diarrhea/constipation issues
☐ Kidney disease
☐ Abnormal bruising/bleeding
☐ Chicken pox
☐ Hyperactivity/ADD/ADHD
☐ Low blood pressure
☐ Rheumatic fever
☐ Respiratory problems
☐ Fainting/seizures
☐ Multiple chemical sensitivities
☐ Liver disease
☐ Anemia
☐ Eye problems
☐ Autism
☐ Depression
☐ Cancer/Tumors

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Methods of Payment For your convenience, we offer the following methods of payment. Please check the option you prefer for payment in full at each appointment:

☐ Cash ☐ Check ☐ VISA ☐ MasterCard ☐ AmEx ☐ Discover

☐ I will need to discuss the of fice's payment policy.

Is your child covered by dental insurance? ☐ Yes ☐ No If 'yes', who is insured?

☐ Mother ☐ Father ☐ Legal guardian ☐ Other ______________________

Dental Insurance Information

Name of insured ______________________ Relationship to patient ______________

Birth date ______________ SS# ______________ Date employed ___ / ___ / ___

Employer ______________________ Work ( ) ______________

Employer's address ______________________ City ______________ Zip ______

Dental insurance company ______________________ Group # __________ Policy ID # ______

Insurance company address ______________________ City ______________ Zip ______

How much is your deductible? $__________ How much have you used? $__________

What is your maximum annual benefit? $__________

Do you have any additional dental insurance? ☐ Yes ☐ No If 'yes', please complete the following:

Additional Dental Insurance Coverage

Name of insured ______________________ Relationship to patient ______________

Birth date ___ / ___ / ___ SS# ______________ Date employed ___ / ___ / ___

Employer ______________________ Work ( ) ______________

Employer's address ______________________ City ______________ Zip ______

Dental insurance company ______________________ Group # __________ Policy ID # ______

Insurance company address ______________________ City ______________ Zip ______

How much is your deductible? $__________ How much have you used? $__________

What is your maximum annual benefit? $__________

Parent 1 / Legal Guardian 1 Contact Information

Name ______ SS# ______ Date ______

Address ______ City ______ Zip ______

Birth date / / Email Please provide the email you check during the week ☐ Male ☐ Female

Home ( ) ______ Work ( ) ______ Cell ( ) ______

Employer's name ______

Employer's address ______ City ______ Zip ______

Parent 2 / Legal Guardian 2 Contact Information

Name ______ SS# ______ Date ______

Address ______ City ______ Zip ______

Birth date / / Email Please provide the email you check during the week ☐ Male ☐ Female

Home ( ) ______ Work ( ) ______ Cell ( ) ______

Employer's name ______

Employer's address ______ City ______ Zip ______

Emergency Contact Please provide a contact in case of emergency (if we cannot reach you)

Name ______ Home ( ) ______ Cell ( ) ______

Whom can we thank for referring you to our practice? ______

Responsible Party for this Account (must be a parent or legal guardian) ______

Relationship to patient ______ Email ______

Birth date / / Home ( ) ______ Cell ( ) ______

Employer ______ Work ( ) ______

Employer's address ______ City ______ Zip ______

What school does your child attend? ______ What grade is s/he in today? ______

What is his/her favorite toy, subject, or hobby? ______

Favorite sports, games or interests? ______

Does your child have any dental anxiety about seeing us today? ☐ Yes ☐ No

Please describe your child's temperament. ______

Is your child up-to-date with their immunizations? ☐ Yes ☐ No If 'no', which needs updating?

____

Dental Health History & Habits

- ☐ Injuries to the mouth/teeth/head
- ☐ Thumbsucking
- ☐ Fingersucking
- ☐ Takes milk/formula to bed in a bottle
- ☐ Uses a sippy cup
- ☐ Child brushes teeth 2-3 times daily
- ☐ Tongue and/or lip pierced
- ☐ Fluoride used/taken in any form
- ☐ Crooked teeth
- ☐ Discolored teeth, some or all
- ☐ Snoring
- ☐ Clicking or popping of jaw
- ☐ Cavities
- ☐ Toothache(s)
- ☐ Nailbiting
- ☐ Uses a pacifier
- ☐ Unusual speech habits
- ☐ Bad breath
- ☐ Mouthbreathing
- ☐ Grinding of teeth during the day or while asleep
- ☐ Swollen gums/painful gums
- ☐ Do you assist child with toothbrushing?
- ☐ Do you assist child with daily or frequent flossing?
- ☐ What toothpaste is used at home ____________

Are there any other dental problems or concerns today? ______________________________

Is this your child's first dental visit? ☐ Yes ☐ No If 'no', date of last visit / /

Name of previous dentist or orthodontist ______________________________

City ______________________________ ( ) ______________________________

Purpose of today's appointment is ______________________________

Thank you for your help in giving us the information we need to best serve your child's dental and/or orthodontic needs/concerns. If you feel there is any information that you think might be of value to us in treating your child, please feel free to comment here:

Authorization and Release I certify that I have read and understand the information in this document to the best of my knowledge. The questions contained in this form have been accurately answered and I understand that providing incorrect information could be dangerous to my child's health. I authorize the treating professionals at West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics to release any information (including but not limited to the diagnosis and records for any treatment or examination) rendered to my child during the period of such dental care to third-party payers and/or health practitioners.

____ ________________________

Signature of parent or legal guardian Date of Signature

Patient Acknowledgement and Agreement I acknowledge that I have read this and fully understand the patient consent and possible future use of electronic mail (email) in sending communications back and forth between parent and the professional staff at West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics as well as email between providers and me and I consent to the conditions outlined herein. In addition, I agree to the instructions outlined herein, as well as any other instructions that West Roxbury Pediatric Dentistry and Orthodontics and/or my dental insurance provider may impose to communicate with patients by email. Any questions on these communications I had have been answered.

____ ________________________

Signature of parent or legal guardian Date of Signature

Statement of Receipt of Privacy Practices I have been provided with West Roxbury Smiles/West Roxbury Pediatric Dental and Orthodontics' Notice of Privacy Practices policy and by signing below I acknowledge receipt of this Policy. This Notice provides me with information about how West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics may use and/or disclose my/my child's protected health information. I further understand and accept that West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics' Notice of Privacy Practices is subject to change. If it should change, I can obtain a copy of the revisions by contacting the practice at 617-327-4321 or emailing westroxburydental@yahoo.com. I acknowledge receipt of the Notice of Privacy Practices for the dental practice of West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics and all its dental professionals and providers.

____ ________________________

Signature of parent or legal guardian Date of Signature

Statement of Financial Responsibility I authorize and request that my dental insurance company pay benefits directly to me. I further understand that my dental insurance carrier may pay less than the actual bill for services incurred with West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics and I agree to be responsible for payment of all services rendered on behalf of that of my dependent(s). In the case of a familial divorce, payment is expected from the parent/guardian who is bringing the patient for treatment. Parents/guardians are expected to work out payment arrangements with each other and not involve West Roxbury Smiles/West Roxbury Pediatric Dentistry and Orthodontics in any disputes that may arise. I agree to assign benefits to the provider should a dental claim be filed. Insurance is filed as a courtesy and I understand regardless of insurance coverage, the balance of this account is my responsibility. I further understand that appointments are confirmed within 24-48 hours prior to my scheduled time via telephone or email to the contact numbers/email address I provide. If I have a dental hygienist appointment to have my teeth cleaned I will receive a postcard 1-2 weeks prior to my appointment. If I need to change an appointment I must provide at least 24 hours' notice so another patient may have my appointment time. If I do not show up for a scheduled appointment time (or give insufficient notice so another patient can be convenienced) I understand and accept that a $75.00/per hour fee may be charged. Patients with a history of failing appointments or repeated late cancellations may be dismissed from the practice without refund.

____ ________________________

Signature of parent or legal guardian initiating consultation or services Date of Signature