HINGHAM
pediatric dentistry

Patients Name _____ Birthdate _____

Nickname_____ Gender: Male/Female

Siblings _____

Home Address _____

Cell Phone _____ Work Phone_____

Daycare/School/College Attending _____

Email address_____

Whom may we thank for referring you? _____

What is the reason for your dental visit?_____

Parent 1
Employer
Occupation

Parent 2
Employer
Occupation

Date of last dental exam?
_____

Date of last dental X-rays?
_____

Name of Previous Dentist?
_____

Does your child brush twice daily?	YES/NO	History of cavities?	YES/NO
Do you use fluoride toothpaste?	YES/NO	History of any pain/tenderness	
Does your child floss daily?	YES/NO	in your jaw joint (TMJ/TMD)?	YES/NO
Is fluoride taken in any other form?	YES/NO	Any mouth habits?	YES/NO
Type_____		Nail biting?	YES/NO
History of tooth pain?	YES/NO	Mouth breathing?	YES/NO
History of trauma to teeth?	YES/NO	Grinding?	YES/NO
History of crowding/orthodontia?	YES/NO	Snoring?	YES/NO
Any dental anxiety/unhappy experiences?		Clenching?	YES/NO
	YES/NO	Bottle Feeding?	YES/NO

Date of last physical_____ **Physician**_____

Any problems at birth?	YES/NO	Please explain:_____
Lip or tongue ties?	YES/NO	Please explain:_____
Are your immunizations up to date?	YES/NO	Please explain:_____
Have you ever had surgery?	YES/NO	Please explain:_____
Do you have any allergies to food?	YES/NO	Please explain:_____
Are you allergic to medications?	YES/NO	Please explain:_____
History of Early Intervention?	YES/NO	Please explain:_____

Have you ever been diagnosed or treated for?

A.I.D.S/HIV	YES/NO
Anemia	YES/NO
Asthma	YES/NO
ADHD	YES/NO
Autism	YES/NO
Anesthesia Complications	YES/NO
Bladder Problems	YES/NO
Blood Clots	YES/NO
Cancer	YES/NO
Cerebral Palsy	YES/NO
Cleft Lip/Palate	YES/NO
Congenital Birth Defects	YES/NO
Convulsions/Seizures	YES/NO
Diabetes	YES/NO
Drug/Alcohol Abuse	YES/NO
Emotional Impairment	YES/NO
Headaches	YES/NO
Hearing Problems	YES/NO
Heart Murmur/Problems	YES/NO
Hepatitis	YES/NO
Infections	YES/NO
Kidney Disease	YES/NO
Learning Disability	YES/NO
Liver Disease	YES/NO
Mental Illness	YES/NO
Physical Disabilities	YES/NO
Sinus Problems	YES/NO
Social Impairment	YES/NO
Sensory Processing Disorder	YES/NO
Speech Problems	YES/NO
Thyroid Problems	YES/NO
Tuberculosis	YES/NO

Please explain on any of the above for which your response was “YES”

_____

Is your child taking any medications? Please list.

_____

CONSENT FOR DENTAL TREATMENT

I consent to receive cleanings, dentist examinations, fluoride treatment and x-rays. Should I agree to a treatment plan, I consent to allow the providers at this office to do sealants, fillings and other common procedures within the standards of care for the duration of my time as a patient at Hingham Pediatric Dentistry. If I wish to not consent to any of the above, I agree to inform the dentist the day of my appointment.

Parent Signature _____ Date_____

FINANCIAL POLICY

PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE ARE RENDERED. WE ACCEPT CASH, PERSONAL CHECK, VISA OR MASTER CARD.

Patients who have dental insurance: Our office will make every attempt to assist you with understanding your benefits; however, it is ultimately your responsibility to be knowledgeable about your policy as well as the deductibles, maximum allowances and other provisions with in said plan. Hingham Pediatric Dentistry will submit claims to your insurance company in a timely mannered will submit pre-treatment estimates to your insurance company. Should you choose to complete your child’s care without receiving an estimate from your insurance, it is your responsibility to contact your carrier with questions. We reserve the right to collect an estimation of what we feel will be due and will refund or credit you any money that was overestimated and reserve the right to bill for what was not collected on the day of service.

Parent Signature _____ Date_____

Dentist Signature _____ Date_____