DENTAL SOLUTIONS OF NORTHBORO

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New Patient Information

Please let us know about your child's medical and dental history so we may serve you more effectively and in a manner that helps with the overall health and well-being of your child.

We realize that not all questions will pertain to your child. If you have questions, please ask and we will help to better explain the question.

Chart#: ____________________
FOR OFFICE USE ONLY

Patient Name: ____________________ ____________________ ____ ____________________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **Prev. Visit:** __________ **Email Address:** ____________________

Phone: __________ __________ __________ ______ **Best time to call:** ____________________
Home Mobile Work Ext

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Who does the child live with?

☐ Mother ☐ Father ☐ Guardian ☐ Grandparents

Siblings who are or who have been a patient in our office:

____

____

Is there anything that you would like to discuss with the Dentist in private, alone, or away from your child? ◯ Yes ◯ No

What is the reason for seeing the dentist today?

☐ First Visit ☐ Check-up ☐ Pain ☐ Other

Whom may we thank for referring you to our practice? Please mark the correct box and name them below.

☐ Another Dental Office ☐ Phonebook ☐ Friend ☐ Driving by ☐ Internet ☐ School

☐ Work ☐ Other (name below):

____

Guardian Information

Unless information is different, this form need only be completed for one child.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Patient Name: ______________ ______________ ____ ______________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: __________ **SS#:** ___-__-____ **DL#:** ______________

Email Address: ______________ **Best time to call:** ______________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ______________ ______________
Address 1 Address 2

______________ ______ _____-____
City State Zip Code

Employer

____

____

Other Guardian Information

Unless information is different, this form need only be completed for one child.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________________ ______________________ ___ ______________________
Last First MI Preferred Name

Title: __________ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: ____________ **Email Address:** ______________________________

Phone: ____________ ____________ ____________ ______ **Best time to call:** ______________________
Home Mobile Work Ext

Address: ______________________________ ______________________________
Address 1 Address 2

______________________________ ______ _____-____
City State Zip Code

Employer

____

____

Dental Benefits Plan

Primary

Name of Insured: ____________________ ____________________ ____

Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____

Plan phone number ____________________

Secondary

Name of Insured: ____________________ ____________________ ____

Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ____

Plan phone number ____________________

Child's Medical & Dental History

Within the past year have there been any changes in your child's general health? ◯ Yes ◯ No

What is the approximate date of your child's last medical exam? ____________

Your child's pediatrician name and phone number:

____

____

Please indicate if your child has experienced any of the following.

☐ *Pre-Med - Amox	☐ *Pre-Med - Clind	☐ *Pre-Med - Other	☐ Allergies
☐ Allergy - Aspirin	☐ Allergy - Codeine	☐ Allergy - Erythro	☐ Allergy - Hay Fever
☐ Allergy - Latex	☐ Allergy - Other	☐ Allergy - Penicillin	☐ Allergy - Sulfa
☐ Anemia	☐ Arthritis	☐ Artificial Joints	☐ Asthma
☐ Blood Disease	☐ Cancer	☐ Diabetes	☐ Dizziness
☐ Epilepsy	☐ Excessive Bleeding	☐ Fainting	☐ Glaucoma
☐ Head Injuries	☐ Heart Disease	☐ Heart Murmur	☐ Hepatitis
☐ High Blood Pressure	☐ HIV	☐ Jaundice	☐ Kidney Disease
☐ Liver Disease	☐ Mental Disorders	☐ Nervous Disorders	☐ Other
☐ Pacemaker	☐ Pregnancy	☐ Radiation Treatment	☐ Respiratory Problems
☐ Rheumatic Fever	☐ Rheumatism	☐ Sinus Problems	☐ Stomach Problems
☐ Stroke	☐ Tuberculosis	☐ Tumors	☐ Ulcers
☐ Venereal Disease			

☐ Had complications with or after dental treatment.
☐ Has been seen by a cardiologist.
☐ Taking any prescription or non-prescription medications.
☐ Any other conditions, diseases, etc. not listed above.
☐ Currently under the care of a physician due to a specific condition.
☐ Been admitted to a hospital in the last 5 years due to a surgery or illness.
☐ Tobacco use (chewing or smoking.)

If any of the previous questions are marked, please explain:

____

____

Has your child been to a different dental office in the last 6 months? ◯ Yes ◯ No

What was done at your child's last dental visit, if to a different office?

____

____

How frequently does you child brush their teeth?

☐ 3+ a day ☐ Twice a day ☐ Once a day ☐ Weekly ☐ Seldom ☐ By parent ☐ By child ☐ Both

Is your child taking a fluoride supplement? ◯ Yes ◯ No

How often does your child floss?

☐ Once daily ☐ Occasionally ☐ Never ☐ By parent ☐ By child

Does your child do any of the following?

☐ Lip sucking/biting ☐ Pacifier ☐ Nail biting ☐ Finger/thumb sucking ☐ Nursing/bottle ☐ Grinds his teeth

☐ Snores

Consent for Services

☐ ***To the best of my knowledge, all of the preceding information is true and correct. If there is any change in my child's health I will inform the office at my child's next dental appointment.**

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnoses and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice, to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependents.

☐ ***I have read the above conditions of treatment and payment and agree to their content.**

Relationship to Patient:

☐ Mother ☐ Father ☐ Guardian ☐ Other

PEDIATRIC DENTISTRY CONSENT FOR ANXIETY REDUCING TECHNIQUES

Please read this form carefully and ask questions about anything you do not understand. Please check each box to identify that you understand this technique.

All effort will be made to obtain the cooperation of child dental patients by the use of Tell - Show - Do with friendliness, persuasion, humor, charm, gentleness, kindness and understanding. In some cases, further techniques are needed when providing operative care such as fillings, etc. In order to gain cooperation, eliminate disruptive behavior or prevent a patient causing injury to themselves, it may be necessary to use other anxiety reducing techniques.

☐ Tell-Show-Do: The dentist or dental team explains to the child what is to be done using simple, kid-friendly terminology and repetition, then shows the child what is to be done by demonstrating with instruments on a model or the child's or the dentist's finger. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

☐ Positive reinforcement: This technique rewards the child who displays behavior which is desirable with compliments, praise, pat on the back, or a prize.

☐ Mouth Props/Rubber Dams: A mouth prop, or tooth pillow as we call it, is used to help support your child in keeping his/her mouth open during an operative procedure (filling, etc). This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a raincoat placed on the area to be worked on to isolate the teeth, and to prevent any debris from being swallowed or from going to the back of the throat.

☐ Immobilization by the dentist: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the dentist gently holds the child's hands or upper body, stabilizing the child's head between the dentist's arm and body

☐ Immobilization by the assistant: In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the assistant gently holds the child's hands and stabilizes the child's head and/or legs.

☐ Relaxation Gas: Nitrous Oxide (laughing gas) and oxygen may be recommended to relax the child. This allows the child to sit in the chair longer, increases their attention span and allows the treatment to be completed in a comfortable manner for the child.

☐ Voice Alteration: A controlled alteration (increase or decrease) of voice, tone, or pace to influence and direct the patient's behavior.

☐ **By checking this box, I acknowledge that I have read this statement and agree to the contents.**

Relationship to patient

☐ Mother ☐ Father ☐ Guardian ☐ Other

Response Date: ____/____/________