



Pediatric Dentistry

of the North Shore, L.L.C.

6 State Road
Danvers, MA 01923
978-777-3744

CHILD'S REGISTRATION AND HISTORY

Child's Name _____ Nickname _____
 Sex Male Female Birthdate _____ Age _____ School _____ Grade _____
 Is this your child's first dental visit? Y N If no, name of former dentist _____
 Is this an emergency visit? Y N Date of last visit _____ Have X-rays been taken? Y N Date _____
 Present dental problem (if any) _____
 Names and ages of siblings: _____
 Have any other children in your family been a patient in this office before? Y N
 Has your child had any bad past dental experiences? Y N Please explain _____
 Favorite interests, sports, pets, etc. _____
 Name of Parent's Dentist _____
 Whom may we thank for referring you to our office? _____

GENERAL INFORMATION

Father's Full Name _____	Mother's Full Name _____
Address _____	Address _____
Home Phone _____ Work Phone _____	Home Phone _____ Work Phone _____
S.S.# _____ Birthdate _____	S.S.# _____ Birthdate _____
Employed by _____	Employed by _____
Occupation _____	Occupation _____
Bus. Address _____	Bus. Address _____

Child lives with both parents mother father other

I understand that I am responsible for all charges incurred whether or not they are paid by insurance.

Signature of parent _____

FOR PATIENTS COVERED BY DENTAL INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
Subscriber Name _____	Subscriber Name _____
Group/Policy Number _____	Group/Policy Number _____
Employer Name _____	Employer Name _____
Insurance Company _____	Insurance Company _____
How long have you had this coverage? _____	How long have you had this coverage? _____

To comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.
I have reviewed the following treatment plan. I authorize release of any information relating to this claim.

Signature of patient (or legal guardian, if minor)

I hereby authorize payment directly to the above-named dentist of the group insurance benefits otherwise payable to me.

Signature of insured person

Please complete the reverse side

MEDICAL INFORMATION

Child's Pediatrician _____ Address _____ Phone _____
 Date of last physical _____ Is your child in good health? Yes No Are your child's immunizations up to date? Yes No
 Is your child presently being treated for any condition? Yes No If so, explain _____
 Is your child taking any medications or drugs? Yes No If so, explain _____
 Has your child ever been hospitalized or had surgery? Yes No If so, explain _____
 Does your child have allergies to any medications? Yes No If so, explain _____
 Does your child have any allergies to the following? pollen food food dyes dust other _____
 Has your child ever been diagnosed as having any of the following conditions? ***Please check "Y" for yes or "N" for no.***

- | | | |
|--|---|--|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> AIDS or H.I.V. | <input type="checkbox"/> <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> <input type="checkbox"/> Anemia | <input type="checkbox"/> <input type="checkbox"/> Congenital Heart Disease | <input type="checkbox"/> <input type="checkbox"/> Leukemia |
| <input type="checkbox"/> <input type="checkbox"/> Asthma | <input type="checkbox"/> <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> <input type="checkbox"/> Autism | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Nutritional Deficiency |
| <input type="checkbox"/> <input type="checkbox"/> Bladder Conditions | <input type="checkbox"/> <input type="checkbox"/> Emotional Disturbances | <input type="checkbox"/> <input type="checkbox"/> Oral Ulcers |
| <input type="checkbox"/> <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> <input type="checkbox"/> Epilepsy | <input type="checkbox"/> <input type="checkbox"/> Orthopedic Problems |
| <input type="checkbox"/> <input type="checkbox"/> Birth Defects | <input type="checkbox"/> <input type="checkbox"/> Eye Problems | <input type="checkbox"/> <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> <input type="checkbox"/> Bone or Joint Problems | <input type="checkbox"/> <input type="checkbox"/> Excessive Bleeding Problems | <input type="checkbox"/> <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> <input type="checkbox"/> Brain Injury | <input type="checkbox"/> <input type="checkbox"/> Excessive Gagging | <input type="checkbox"/> <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> <input type="checkbox"/> Bruising Easily | <input type="checkbox"/> <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> <input type="checkbox"/> Cancer or Malignancies | <input type="checkbox"/> <input type="checkbox"/> Growth & Development Problems | <input type="checkbox"/> <input type="checkbox"/> Syndrome _____ |
| <input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> <input type="checkbox"/> Hearing/Speech Problems | <input type="checkbox"/> <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> <input type="checkbox"/> Child Abuse | <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> <input type="checkbox"/> Chronic Adenoid/Tonsil Infection | <input type="checkbox"/> <input type="checkbox"/> Hemophilia | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Chronic Headaches | <input type="checkbox"/> <input type="checkbox"/> Hepatitis or Liver Disease | _____ |
| <input type="checkbox"/> <input type="checkbox"/> Chronic Ear Infections | <input type="checkbox"/> <input type="checkbox"/> Hyperactivity/A.D.D. | _____ |

Please describe any current medical treatment including drugs, pending surgery, recent injuries or other information that has not been covered: _____

DENTAL INFORMATION

Was your child bottle fed? Yes No Was your child breast fed? Yes No If yes, until what age _____
 Does your child drink juice, milk, etc. near bedtime? Yes No
 Has your child had injuries to his/her teeth, mouth, head, or jaws? If yes, describe _____
 Does your child brush daily? Yes No Does your child floss daily? Yes No Does an adult assist? Yes No
 Does your child have any of these oral habits? thumb or finger sucking pacifier mouth breathing teeth grinding nail biting
 Does your child report any pain during chewing or while opening the mouth wide? Yes No
 Does your child report any discomfort in the jaws upon awakening? Yes No
 Is there a history of trauma to the jaws or neck region? Yes No
 Does your child receive fluoride in any of the following forms? vitamins water supply tablets/drops toothpaste rinse/gel
 Please check any of the following that may describe your child:

- Outgoing Shy Stubborn Anxious Cautious Frightened Defiant Curious Moody
High Strung Friendly Cooperative Other _____

What do you expect as your child's reaction to today's visit? excellent good poor don't know
 How may we help to make this a positive experience for your child? _____

CONSENT FOR TREATMENT

I hereby authorize and direct the dentists and the staff of Pediatric Dentistry of the North Shore, LLC to provide dental care for my child.

Name of child _____ Signature of legal guardian _____ Date _____

Reviewed by _____ Date _____