

CM Vera DMD
Matthew W. Panagiotu DDS
144 Pleasant Street
Worcester, MA 01609
508-754-9825

Patient Information

Date _____

Last Name	First Name	Nickname	Gender	Birthdate
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Home Address	Town, Zip
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Cell Phone	Home Phone	Work Phone
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Email Address	Preferred Contact Method
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Father's Name	Birthdate	Occupation/Employer
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Mother's Name	Birthdate	Occupation/Employer
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Parents' Information Single Separated Married Divorced Widowed

Previous or Family Dentist	Telephone
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Child's Physician	Telephone
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How did you hear about us?

Last Cleaning:

WORCESTER KIDS' DENTIST

Financial Policy

Patient's Name _____

Payment is due when services are rendered. We accept cash, personal checks, Mastercard, Visa. We will send a pre-estimate to your insurance company if requested. Please see our billing manager regarding this. In the case of divorce, the parent bringing the child to the office will be deemed financially responsible. I have read the above information and understand my obligations.

Signature of Financially Responsible Party

Insurance Information

Primary Dental Insurance Company

Secondary Dental Insurance Company

Name _____

Name _____

Name of Insured _____

Name of Insured _____

SS# _____

SS# _____

Subscriber DOB _____

Subscriber DOB _____

City, State _____

City, State _____

Employer of Insured _____

Employer of Insured _____

Person Responsible for the Account

Billing Address

I authorize my insurance company(ies) to pay benefits directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I will be responsible for all copayment, deductible and rejected charges.

Signature

Date

Consent for Dental Treatment

I request and authorize Dr Vera and/or Dr Panagiotu and their staff to examine, clean and provide my child with routine dental treatment which may include x-rays, fillings, crowns, extractions and local anesthesia. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr Vera and Dr Panagiotu will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments and using variable voice tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature Legal Guardian

Print Name

Date

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Child Health History

Name of Child _____ DOB _____

1) Was your child premature? Yes No

2) Were there any difficulties during the pregnancy, delivery or first year of life? Yes No
 Explain _____

3) Is a physician treating your child now for a specific illness? Yes No
 Explain _____

4) Is your child taking any medications at this time?

DRUG	FREQUENCY	DOSE	REASON

5) Has your child taken any medication in the past? Yes No
 Explain _____

6) Has your child any allergies or unusual reactions to the following?
 a) Medications Yes No Foods Yes No Latex Yes No
 b) Other Yes No
 Explain _____

7) Has your child ever been hospitalized? Yes No
 Explain _____

8) Has your child ever had an operation? Yes No
 Explain _____
 a) Was general anesthesia used? Yes No
 b) Any complications? Yes No
 Explain _____

9) Are your child's immunizations up-to-date? Yes No

10) Has your child ever been diagnosed with any of the following conditions? Please check yes or no.

- | | | |
|--|---|---|
| <p>Y N</p> <input type="checkbox"/> Anemia
<input type="checkbox"/> Asthma
<input type="checkbox"/> Autism
<input type="checkbox"/> Blood Transfusions
<input type="checkbox"/> Birth Defects
<input type="checkbox"/> Bone or joint problems
<input type="checkbox"/> Brain Injury
<input type="checkbox"/> Bruising Easily
<input type="checkbox"/> Cancer or malignancies
<input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> Child Abuse
<input type="checkbox"/> Chronic Adenoid/tonsil
<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Chronic Ear Infections
<input type="checkbox"/> Cleft lip/palate | <p>Y N</p> <input type="checkbox"/> Congenital Heart Disease
<input type="checkbox"/> Convulsions/Seizure
<input type="checkbox"/> Diabetes
<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Eye Problems
<input type="checkbox"/> Excessive Bleeding Problems
<input type="checkbox"/> Excessive Gagging
<input type="checkbox"/> Fainting or Dizziness
<input type="checkbox"/> Growth/Dev. Problems
<input type="checkbox"/> Hearing/Speech Problems
<input type="checkbox"/> HIV
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis or liver disease
<input type="checkbox"/> Hyperactivity | <p>Y N</p> <input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Leukemia
<input type="checkbox"/> Mental Retardation
<input type="checkbox"/> Oral Ulcers
<input type="checkbox"/> Orthopedic Problems
<input type="checkbox"/> Premature Birth
<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Scoliosis
<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Syndrome
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other |
|--|---|---|

Signature Legal Guardian _____ Print Name _____ Date _____

 Doctor/Date