

Worcester Kids' Dentist
 41 Lancaster Street, Worcester, MA 01609
 508-754-9825
Child Health History

Name of Child _____ DOB _____

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

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

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

DRUG	FREQUENCY	DOSE	REASON

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

5) Does your child have any allergies or unusual reactions to the following?
 A) Medications Yes No Foods Yes No Latex Yes No
 B) Other Yes No
 Explain _____

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

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

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

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

- | | | |
|---|--|--|
| Y N
<input type="checkbox"/> ADD
<input type="checkbox"/> ADHD
<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 | Y N
<input type="checkbox"/> Chronic Adenoid/tonsil issues
<input type="checkbox"/> Chronic Headaches
<input type="checkbox"/> Chronic Ear Infections
<input type="checkbox"/> Cleft lip/palate
<input type="checkbox"/> Convulsions/Seizure
<input type="checkbox"/> Developmental Delay
<input type="checkbox"/> Diabetes
<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"/> HIV
<input type="checkbox"/> Hearing/Speech Issues | Y N
<input type="checkbox"/> Heart Murmur
<input type="checkbox"/> Hemophilia
<input type="checkbox"/> Hepatitis or liver disease
<input type="checkbox"/> Hyperactivity
<input type="checkbox"/> Growth/Dev. Problems
<input type="checkbox"/> Mental Health Issues
<input type="checkbox"/> Oral Ulcers
<input type="checkbox"/> Premature Birth
<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Other |
|---|--|--|

Signature Legal Guardian _____ Print Name _____ Date _____

 Doctor Signature/Date

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DENTAL HEALTH:

1) Why did you bring your child to the dentist today? _____

2) How long has it been since your child's last dental exam? _____ last tooth cleaning? _____
First visit ever? _____

3) For most drinking & cooking do you use: town water well-water bottled water

If well of bottled, has the water been tested for fluoride? No Yes

Results? _____

4) Does your child take fluoride supplements? Yes No

Dose _____ Frequency _____

5) Have there been any injuries to the face, mouth, or teeth? Yes No

Please give dates and descriptions _____

6) Has your child ever sucked a thumb or fingers? Yes No

Pacifier? Yes No

Any other habits? _____ For thumb, pacifier or other habits until what age? _____

7) Does your child have:

Y N

Snoring

Daytime mouth breathing

Nighttime mouth breathing

Frequent Middle Ear Infections

Y N

Tooth Grinding

Bedwetting Now

Hearing Deficiency

Y N

History Of Sleep Apnea

Restless Sleep

Speech Problems

Environmental Allergies

8) Have you been informed of any missing or extra permanent teeth? Yes No

9) Are there any unusual sounds in ear (clicking) during eating? Yes No

10) Has your child ever had an orthodontic examination or orthodontic treatment? Yes No

11) Does your child go to sleep with a bottle, with a sippy cup, or while nursing? Yes No

Until what age? _____

12) Is your child nervous or frightened during dental visits? If yes, please circle

Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

13) It would be helpful if you would indicate below what things you are looking for most in choosing a pediatric dentist.

14) Has your child had any unfavorable medical or dental experience? Yes No

If so, please explain _____

Signature Legal Guardian

Print Name

Date

Doctor Signature/Date

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Patient Information

Date _____

Last Name First Name Middle Initial Gender Birthdate

Social Security #: Home Address City/Town, Zip

Cell Phone Home Phone Work Phone/ Mother Work Phone/Father

Email Address Preferred Contact Method

Father's Name Birthdate SSN # Occupation/Employer

Mother's Name Birthdate SSN# Occupation/Employer

Parents' Information Single Separated Married Divorced Widowed

Custody Information:

1. Shared Custody: State name of each parent or guardian _____ and _____
**** Written authorization by the non-attending parent and/or guardian must be received by Worcester Kids' Dentist prior to commencement of any and all dental treatment.**

2. Sole Custody: State name _____

State relationship to child: _____

***Copy of the most recent Court Order must be provided to Worcester Kids' Dentist prior to commencement of any and all dental treatment.**

Previous or Family Dentist Address: Telephone

Child's Physician Telephone Urgent medical conditions/alerts

How did you hear about us? Website Referral/by whom

Date of Last Cleaning: Last date of most recent x-rays

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FINANCIAL POLICY

In effort to avoid any misunderstanding, we would like to review our Financial Policy before you or your child begins dental treatment in our office.

Initial Below:

- ✓ Please be aware that federal law makes the parent who brings a child and authorizes the medical/dental treatment responsible for payment of fees, regardless of other contracts or agreements.
- ✓ Payment is expected for treatment rendered at the time of service. We accept MC/Visa/Discover/Debit, checks and cash. For extensive services, we offer payment plans.
- ✓ If you are in need of an extended finance option, we also work with Care Credit, which offers 3,6,12 or 18 month "same as cash" or longer terms, with an interest bearing revolving charge designed to meet your treatment plan needs, on approved credit. Please see our billing manager regarding Care Credit.
- ✓ A return check fee of \$40 will be charged for all returned checks.
- ✓ A specific amount of time is reserved especially for you or your child, and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hour notice.
- ✓ If you "no call / no show" to an appointment, there will be a broken appointment fee of \$75.
- ✓ I agree to pay a finance charge if my account is overdue.
- ✓ The parent/legal guardian bringing the child to the office is deemed financially responsible for the account.
- ✓ We will send a pre-estimate to your insurance company, if requested.

FINANCIAL POLICY FOR PATIENTS WITH DENTAL INSURANCE

You will need to supply us with the subscriber information (name, date of birth, SSN#, employer, ID# and/or group #), as well as the name and address of your insurance company. Any specific questions you may have relative to your insurance coverage should be made, by you, directly to your insurance company. It is your responsibility to confirm that Worcester Kids' Dentist is listed as a provider on your specific plan.

As a courtesy, we will gladly submit an insurance claim to your insurance company. We will collect your estimated co-payment and deductible from you at the time of service, and your insurance company will pay our office directly. We make every effort to determine benefits when you or your child receive treatment, but consider your co-payment to be an **estimate** until we receive the actual payment from your insurance company.

Please bear in mind that any information that we provide relative to your insurance benefits is just our best **estimate**, and is not a guarantee of the payment that will be received.

Name: _____ Signed: _____

Date: _____

We always welcome comments from you, whether they are positive or negative in nature. Without your critique, we have no way of knowing how to improve our practice. We want to be responsive to your needs and your feedback is essential to our understanding those needs!

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Insurance Information

Primary Dental Insurance Company

Name _____

Name of Insured _____

SS# _____

Subscriber DOB _____

City, State _____

Employer of Insured _____

Secondary Dental Insurance Company

Name _____

Name of Insured _____

SS# _____

Subscriber DOB _____

City, State _____

Employer of Insured _____

Person Responsible for the Account

Billing Address

I authorize my insurance company (ies) to pay benefits directly to Worcester Kids' 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

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Consent for Dental Treatment

_____ I request and authorize the doctors and 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. Worcester Kids' Dentist 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.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

_____ I have received a copy of this office's Notice of Privacy Practices.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign

- An emergency situation prevented us from obtaining acknowledgement

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PHOTOGRAPHY CONSENT FORM/RELEASE FOR MINOR CHILDREN (Under 18)

_____ I hereby grant permission to Worcester Pediatric Dental Group, Inc. (hereafter referred to as "WKD") staff, to take and use: photographs of my child for use in news releases, social media and/or educational materials as follows: printed publications or materials, electronic publications, or web sites. I agree that my child's first name: may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me, without expiration. All images and reproductions and shall be the property of WKD.

_____ I do NOT grant permission to Worcester Pediatric Dental Group, Inc. (hereafter referred to as "WKD") staff, to take and use photographs of my child for public use. I understand, however, that photos may need to be taken for clinical purposes – such as for documenting pathology, treatment or for orthodontic records. Consent for these photos will be obtained on a case by case basis.

Signature Legal Guardian

Print Name

Date

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Our practice sees many children from many different walks of life. We ask you to certify that you have legal authority to make healthcare decisions for your child, and to update us if that authority changes through adoption, divorce or other circumstances. From time to time, you will be asked to re-execute this form, along with other important documents in your child's medical/dental record.

I, _____, have the legal authority to consent to treatment for the below listed child (ren). If authority is related to a legal ruling or court order, I am attaching a copy of the relevant paperwork. I agree to update this form if my legal authority changes.

Patient Name: _____ Patient Name: _____

Date of Birth: _____ Date of Birth: _____

Patient Name: _____ Patient Name: _____

Date of Birth: _____ Date of Birth: _____

Please note: Only a legal guardian or parent with custody can consent to procedures such as treatment using nitrous oxide (laughing gas) and extractions. Please consider that when your child is coming in for a procedure that requires written consent.

Signature of parent/guardian

Date