Southborough Dental Associates

DATE OF RECORD ___/___/___

REVIEWED BY _______________

PATIENT INFORMATION

PERSONAL

Patient's Last Name ____ First Name ____ Home Telephone ____ Birthdate ____

Nickname ____ Sex ____ Street Address ____ Town ____ Zip ____

Previous Address if < 3 yrs. at Current Address ____ Town ____ State ____ Zip ____

Father's Name ____ Birthdate ____ Social Security # ____ Employer ____

Mother's Name ____ Birthdate ____ Social Security # ____ Employer ____

Age and Name of Siblings ____________________

PARENTS' INFORMATION

__ Single __ Separated __ Married __ Divorced __ Widowed

Person responsible for the Account ____ Billing Address ____

Father's Work # ____ Mother's Work # ____

Previous or Family Dentist ____ Telephone ____

Child's Physician ____ Telephone ____

Whom can we thank for referring you ____________________

Address ____________________

MEDICAL HISTORY

1. Were there any difficulties during the pregnancy, delivery or first year of the child's life? ___ Yes ___ No
   If so, what? ____________________
2. Was your child premature? ___ Yes ___ No
3. Is a physician treating your child now for a specific illness? ___ Yes ___ No
   If so, for what reason? ____________________
4. Is your child taking any medication at this time? ___ Yes ___ No

Drug	Dose	Frequency	Reason

5. Has your child taken any unusual medications in the past ___ Yes ___ No

   If so, what? ______________________ For what reason? ______________________

6. Has your child shown any allergies or unusual reactions? ___ Yes ___ No
   a. Medications or drugs ______________________
   b. Foods ______________________
   c. Latex ______________________
   d. Other ______________________
7. Has your child ever been hospitalized? ___ Yes ___ No
   If so, when? ______________________

   For what reason? ______________________

8. Has your child had any operations? ___ Yes ___ No
   If so, when? ______________________

   For what reason? ______________________

   Was general anesthesia used? ___ Yes ___ No

   Any complications, if so, what? ______________________

9. Are your child's immunizations up to date? ___ Yes ___ No
10. Does your child have any history of the following diseases or conditions? (if "yes" check off boxes that apply)

___ Rheumatic fever	___ Hepatitis	___ Sickle Cell Disease or Trait
___ Heart Disease	___ Tuberculosis	___ Cystic Fibrosis
___ Jaundice	___ Bleeding Problem	___ Leukemia or Tumors
___ Diabetes	___ Seizures	___ Kidney Disease
___ Asthma	___ Anemia	___ Cerebral Palsy
___ Liver Disease	___ Child Abuse	___ AIDS

___ Heart Murmur, Type? ______________________

___ Learning Disabilities, Type? ______________________

___ Emotional Disabilities, Type? ______________________

___ Hearing Difficulty, Type? ______________________

___ Speech Difficulty, Type? ______________________

___ Developmental Disability or Delay, Type? ______________________

11. Does your child bruise easily? ___ Yes ___ No

12. Has there ever been any history of spontaneous bleeding (e.g. nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? ___ Yes ___ No

Remarks: ______________________

____

DENTAL HEALTH HISTORY

1. Please check reason(s) for seeking dental care

___ First Examination	___ Routine check-up	___ Toothache or swelling
___ Appearance of teeth	___ Crowding of teeth	___ Accident

___ Other, ______________________

2. If your child has been to a dentist previously ___ Yes ___ No
   a. When was the last visit? ______________________
   b. Have x-rays been taken and when? ______________________
   c. How would you describe your child's temperament? ______________________

3. How do you think your child will react to dental treatment? ____________________

4. Has your child had fluoride in any of the following forms?

   Fluoride tablets or in vitamins (Fluoride amt. .25 .5 1.0 mg) ___ Yes ___ No

   Drinking water (community fluoridation) ___ Yes ___ No

   Topical application to teeth; last ____________________

   Toothpaste; brand ____________________

5. Does your child brush his / her own teeth? ___ Yes ___ No

   How frequently and when? __ AM __ PM __ After Snacks __ Before Bed __ After Breakfast

6. Do you brush your child's teeth? ___ Yes ___ No

   How frequently and when? __ AM __ PM __ After Snacks __ Before Bed __ After Breakfast

7. Do you or your child use dental floss in cleaning your child's teeth? ___ Yes ___ No

   How frequently and when? __ AM __ PM __ After Snacks __ Before Bed __ After Breakfast

8. Does your child have between meal snacks? ___ Yes ___ No

9. Have your child's teeth ever been injured? ___ Yes ___ No

   When? __________ Which Teeth? __________ Cause? __________

   Were the teeth treated? ___ Yes ___ No

   If so describe treatment ____________________

10. Does your child have any of the following habits?

    ___ Thumb or finger sucking

    ___ Lip sucking or biting

    ___ Other ____________________

    ___ Bottle to bed at night

    ___ Pacifier

    ___ Breaths through mouth

11. Has your child received any unusual dental or surgical treatment to the mouth? ___ Yes ___ No

    If so, what? ____________________

I hereby give permission to Southborough Dental Associates to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, topical and local anesthetic (injections), voice control, radiographs, etc.

Signature of legal Guardian ____________________ **Date** __________

RE-EVALUATION OF ORIGINAL PATIENT INFORMATION FORM

DATE	NO CHANGE	CHANGES	PARENTS INITIAL

INSURANCE INFORMATION

NAME OF POLICY HOLDER	GROUP NUMBER	SOCIAL SECURITY #
NAME OF EMPLOYER	EFFECTIVE DATE	
NAME OF INSURANCE COMPANY		
SECONDARY COVERAGE (DENTAL)		

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DENTIST OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

x____

Signed (insured person)

SOUTHBOROUGH DENTAL ASSOCIATES
11 MAIN STREET
SOUTHBOROUGH, MASSACHUSETTS 01772
TELEPHONE (508) 481-6100

Statement of Treatment and Consent Form for Minors

Southborough Dental Associates is dedicated to rendering the best possible care to your children. Our experience and guidelines established by the American Dental Association will determine which of the following procedures will be performed.

- Dental Cleaning
- Annual Cavity Detecting Radiographs (Bitewing X-rays)
- Additional Radiographs for Diagnostic Purposes
- Topical Fluoride Treatment

General Office Policy

Parents are not routinely allowed in the treatment room except in an emergency situation. Your child will receive exceptional care and will respond better to the doctor or hygienist in a one-on-one situation. If your family is new to our office, an initial exam may be scheduled in order for you and your child to meet our staff. Please address any concerns you may have with any member of our caring staff.

Please review the list and sign below.

I give Southborough Dental Associates permission to render the above treatment to

_______________________________________.

_______________________________________	_______________________
Signature of Parent or Guardian	Date