Commonwealth Pediatric Dental

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Patient Name: _____ Preferred Name: _____

Date of Birth: _____ Male: _____ Female: _____

Address: _____ City: _____ State: _____ Zip: _____

Are there any other family members seen by our practice? Please Name: _____

Is your child adopted? _____ Is your child in foster care? _____

Whom may we thank for referring you to our practice? _____

Parent/Guardian Information

Mother ◯ Father ◯ Guardian ◯

Name _____

SSN _____

Date of Birth _____

Address(if other) _____

_____

Home Phone _____

Cell Phone _____

Work Phone _____

Employer _____

Email _____

Married ____ Single ____ Partnered ____ Divorced ____

Mother◯ Father ◯ Guardian◯

Name _____

SSN _____

Date of Birth _____

Address(if other) _____

_____

Home Phone_____

Cell Phone_____

Work Phone _____

Employer _____

Email _____

Married ____ Single ____ Partnered ____ Divorced ____

Child resides with? _____ **Who is accompanying the child today? _____**

The parent/relative or guardian that accompanies a child for his/her appointment will be responsible for any payment ***at the time*** services are rendered. Reimbursement must be made between divorced parents. Our office will ***not*** intervene.

Insurance Information (Primary)

Subscriber Name: _____ Date of Birth: _____

Employer: _____ Relationship to child: _____

Insurance Company: _____ Phone: _____

Group Number: _____ Subscriber Number: _____

Insurance Information (Secondary)

Subscriber Name: _____ Date of Birth: _____

Employer: _____ Relationship to child: _____

Insurance Company: _____ Phone: _____

Group Number: _____ Subscriber Number: _____

Dental History

Please answer all the following questions completely.

Has your child ever been to the dentist before? Y / N If yes, name of office _____

Has your child ever had dental x-rays taken? Y / N If yes, approximate date _____

Has your child ever had local anesthesia (novacaine)? Y / N Has your child ever had nitrous oxide? Y / N

Has your child experienced any unfavorable reaction from previous dental care? Y / N

If yes, please explain _____

Does/did your child suck a **finger**, **thumb**, or **pacifier**? Y / N **If yes, please circle which one**

Was your child **breast fed** or **bottle fed** (please circle) At what age did they stop? _____

Is your home water supply fluoridated? Y / N Does your child use toothpaste containing fluoride? Y / N

Do you give your child any form of fluoride? Y / N If yes, what? _____

Is your child currently experiencing any pain while yawning, chewing, or opening wide? Y / N

Is your child having any problems with any of the following?

Please Circle

Cavities Toothache Sensitive Teeth Trauma Gum Infections

Color of Teeth Orthodontics Jaw Sounds Other: _____

Health History

Please answer all the following questions completely.

Is your child in good health? Y / N Date of last medical checkup? _____

Name of child's physician? _____ Phone: _____

Pharmacy: _____ Phone: _____

Were there any problems at birth? Y / N If yes, please explain: _____

Has your child ever had any serious health problems? Y/ N If yes, please explain _____

_____

Has your child ever been hospitalized or had any surgeries? Y / N If yes, please explain _____

_____

If your child currently taking any medications? Y / N If yes, please list: _____

Does your child have any food allergies? Y/ N If yes, please list: _____

Is your child allergic to any medications? Y / N If yes, please list: _____

Please circle if your child has ever been treated for any of the following:

Anemia	Autism	Rheumatic/Scarlet Fever	Hepatitis A
Blood Disorders	Cerebral Palsy	Congenital Birth Defect	Hepatitis B or C
Bleeding/Transfusions	Cleft Lip/Palate	Heart Defect	AIDS/HIV+
Bruise Easily	Developmental Delays	Heart Murmur (MVP)	Kidney Disease
Hemophilia	Handicap/Physical Delays	Heart Valve (Artificial)	Liver Disease
Sickle Cell Disease	Speech/Hearing Impaired	Heart Disease	Cancer/Chemo
Diabetes	Visually Impaired	Frequent Infections	Epilepsy
ADHD	Asthma	Fever Blister/Cold Sores	Seizures
Asperger's Syndrome	Seasonal Allergies	Headaches	Thyroid Problems

Is your child allergic to any of the following?

Please circle any that apply

Aspirin	Metals	Amoxicillin	Dental Anesthetics
Latex	Erythromycin	Jewelry	Tylenol
Codeine	Penicillin	Sulfa	

Do you consider your child to be

Please check

_____ Advanced in the learning process

_____ Progressing normally

_____ Delayed in the learning process

Is your child shy? Y / N

Does your child adjust well to new situations? Y / N

Do you have any other questions or concerns?

_____

_____

Family Medical and Dental History

Please indicate if any immediate family member has/have had any of the following.

Allergies? Y / N If yes, which family member(s)? _____

Allergic to? _____

High Decay Rate? Y / N If yes, which family member(s)? _____

No/Minimal Decay Rate Y / N If yes, which family member(s)? _____

Extra teeth? Y / N If yes, which family member(s)? _____

Missing teeth? Y / N If yes, which family member(s)? _____

Orthodontic Treatment? Y / N If yes, which family member(s)? _____

Acknowledgement of Information

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my child's medical status.

Parent/Guardian Signature: _____ Date: _____

Consent for Dental Treatment

I request and authorize Dr. Raymond Murphy and staff to examine, clean and provide dental treatment as necessary on my child. I further request and authorize the taking of dental x-rays. I understand that dental treatment for children include efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. I understand that an environment will be created to help children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments, as well as using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment. It is our office policy to collect patient's estimated portion at the time of service. All financial arrangements must be made in advanced. I authorize Commonwealth Pediatric Dental to access my insurance information.

Parent/Guardian Signature: _____ Date: _____

Missed Appointments/Short Notice Cancelations Policy

We strive to render excellent dental care to your child and the rest of our patients. To be consistent with this, we have an Appointment Cancelation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient. We do request a 48-hour cancelation notice; however, we do understand emergencies can happen. We ask you be respectful of our policy and let us know as soon as you know you will not be able to make your appointment. Patients who do not show up to their appointments will be considered a no-show. More than 3 no shows in a 12-month period may be considered for dismissal from our practice.

Parent/Guardian Signature: _____ Date: _____

Composite/Tooth Colored Filling Consent

A composite resin is a tooth-colored plastic mixture filled with glass (silicone dioxide). First introduced in the 1960's, studies have now shown that composites have strength, durability, and longevity comparable to silver fillings. Esthetics is far superior over silver fillings. The dentist can blend shades to create a color nearly identical to that of the actual tooth. Composites also bond to the tooth to support the remaining tooth structure, which helps prevent breakage and insulate the tooth from excessive temperature changes.

Our office only places composite resin fillings. Please note, most dental insurance plans do not cover the entire cost of the composite fillings. This may result with the patient being responsible for paying a modest balance. If you have any questions regarding your individual insurance coverage we recommend you review your insurance policy prior to your appointment.

Parent/Guardian Signature: _____ Date: _____

Acknowledgement of Receipt of Privacy Practices and Consent for Use and Disclosure of Health Information

You have the right to read our Privacy Practices before you decide whether to sign this consent. A copy of our Notice and/or this consent is available upon request. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we make or your protected health information.

Purpose of Consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. I have been shown a copy of this office's Notice of Privacy Practices and have had full opportunity to read and consider its contents. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

If this consent is signed by a personal representative on behalf of a patient, please complete the following:

Patient's Name: _____ Date: _____

Parent/Guardian Signature: _____ Relationship to Patient: _____

Our office firmly believes a strong patient/doctor relationship is based upon good understanding and communication. Any questions or concerns regarding our policies may be directed towards our front office staff. Thank you.