

Core Pediatric Dentistry

5 Hampton Road ~ Exeter, NH 03833
Tel: 603.773.4900 ~ Fax: 603.775.7648
www.corephysicians.org/Pedi-Dental

• ♦ • PATIENT INFORMATION • ♦ •

TELL US ABOUT YOUR CHILD

Child's name: _____

Nickname: _____

Age: _____ Date of Birth _____

Male Female Other

Child's Social Security: _____

Address: _____

City / State / Zip: _____

Home Phone #: _____

Primary Care Physician: _____

Primary Care Physician Phone #: _____

Pharmacy Name: _____

Pharmacy Location _____

GETTING TO KNOW YOU

Is another member of your family a patient at our office?

Yes No If yes – Name _____

How did you hear about us?

- Another patient Relative or Friend
 Pediatrician Dental Office
 Internet/ Web Site Insurance Company

Other: _____

Phone number you would like us to use to confirm your appointments _____

Email Address _____

Emergency Contact Name _____

Emergency Contact Phone # _____

Parent Information

Marital Status of Parents:

- Married Divorced Single Separated Widowed Life Partner

Parent # 1 Information Step Guardian

Name _____ Birth Date _____

Address: _____

City / State / Zip: _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

Parent # 2 Information Step Guardian

Name _____ Birth Date _____

Address: _____

City / State / Zip: _____

Home Phone #: _____

Cell Phone #: _____

Work Phone #: _____

PRIMARY DENTAL INSURANCE

Ins.Co Name _____

ID# _____

Group #: _____

Customer Service Phone #: _____

Subscriber Name _____

DOB _____ Subscriber SSN # _____

Subscriber Employer Name _____

SECONDARY DENTAL INSURANCE

Ins.Co Name _____

ID# _____

Group #: _____

Customer Service Phone #: _____

Subscriber Name _____

DOB _____ Subscriber SSN # _____

Subscriber Employer Name _____

Patient Name: _____

AUTHORIZATIONS

General Consent for Treatment:

I hereby give my consent to the dentists and other clinical personnel of Core Physicians for the evaluation and treatment of me on an on-going basis. I understand that I have the right to revoke this consent in writing, at any time, except when the physicians or other clinical personnel have already taken action on my consent.

Consent to Treat a Minor:

Core Physicians must have permission from the parent or legal guardian before an evaluation or any medical treatment can be given to a minor (a person under the age of 18).

I, _____, am the parent or legal guardian having legal custody of _____, a minor, age _____, born _____.

I hereby give my consent to the dentists and other clinical personnel of Core Physicians for the evaluation and treatment of this minor on an on-going basis.

Assignment of Insurance Benefits and other Releases of Medical Information:

I hereby authorize any insurance benefits to be paid directly to the dentist providing services and recognize my responsibility to pay for all non-covered services. I also authorize the dentist or any holder of medical information to release any information necessary to process an insurance claim. I understand that this release of information may include a release to companies that Core Physicians has contracted with to provide services for Core and under those contracts the individuals and companies have agreed to keep any personal health information confidential and to protect it from further disclosure.

Acknowledgement of Receipt of Privacy Practices:

I, the undersigned, understand that Core Physicians is required by law to maintain the privacy of protected health information and provide me a notice of their legal duties and privacy practices regarding health information about me. My signature below attests that I have read, understood, and agree with the Notice of Privacy Practices that describes how medical information about me may be used and disclosed and how I can have access to this information.

Signature of Parent or Guardian

Printed name of Parent or Guardian

Date

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• ♦ • YOUR CHILD'S HEALTH HISTORY • ♦ •

Name: _____ Birth Date: _____

DENTAL HISTORY

Is this your child's first dental visit? Yes No If no, name of former Dentist: _____

Have x-rays been taken? Yes No Don't Know X-ray date: _____

Reason for today's visit: _____

Is this an emergency visit? Yes No

Has your child had any unhappy dental experiences? Yes No Explain: _____

Any injuries to mouth or teeth? Yes No Explain: _____

Does your child have any of the following oral habits? Thumb or Finger Sucking Pacifier Mouth Breathing

Was your child bottle fed? Yes No Until what age? _____

Does your child drink juice or milk before bedtime? Yes No

Does your child snack frequently? Yes No

Does your child brush daily? Yes No Does an adult assist? Yes No

What is your water supply at home? Town Water Well Water

Does your child receive fluoride in any of the following forms? (check all that apply)

Water Supply Tablets/Drops Vitamins Rinse/Gel Toothpaste

How do you expect your child to react to today's visit? Excellent Good Poor Don't Know

Please check any of the following that may describe your child:

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

Other: _____

Today's Date _____ Patient Name: _____ DOB _____

MEDICAL HISTORY

Patient's Primary Care Physician _____ Date of last physical examination: _____

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

Is your child presently being treated for any condition? Yes No

Explain: _____

Is your child receiving any medications or drugs? Yes No

Explain: _____

Has your child ever been hospitalized or has surgery? Yes No

Reason: _____

Does your child have any allergies to medications? Yes No

List: _____

Any other Allergies? Latex Food Dust Other: _____

Does your child have any heart conditions/heart murmurs? Yes No

Explain: _____

Does your child have any learning difficulties? Yes No

Explain: _____

Has your child ever been diagnosed with having any of the following conditions:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> AIDS or HIV | <input type="checkbox"/> Allergies (explain below) | <input type="checkbox"/> Anemia | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism | <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Bone/Joint Problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Emotional Problems | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Eye/Vision Problems | <input type="checkbox"/> Excessive Bleeding |
| <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Growth/Development Problems | <input type="checkbox"/> Hearing/Speech Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Hyperactivity/ADD |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Intellectual Disability |
| <input type="checkbox"/> Nutritional Deficiency | <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Premature Birth |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Scoliosis | <input type="checkbox"/> Sickle Cell Anemia | <input type="checkbox"/> Syndrome (explain below) | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Speech Problems | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Other (explain below) | <input type="checkbox"/> Anxiety/ Depression |

Please explain any of the above conditions and provide other medical information we should know about your child:

To the best of my knowledge, all of the answers and information provided are true and correct. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

Signature of Parent or Legal Guardian

Date

Dr. Acknowledgement: