Pediatric Dental Healthcare

Specialists in Pediatric Dentistry and Orthodontics

MEDICAL / DENTAL HISTORY UPDATE

(FOR THE SAFETY OF OUR PATIENTS, WE REQUIRE A MEDICAL HISTORY UPDATE EVERY 6 MONTHS)

CHILDS NAME_____DOB_____

DO YOU HAVE ANY CONCERNS/QUESTIONS ABOUT YOUR CHILD'S DENTAL HEALTH THAT WE CAN ANSWER TODAY?

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ANY ALLERGIES? _____

IN ORDER TO KEEP YOUR CHILD'S RECORD UP TO DATE AND ACCURATE, PLEASE CHECK OFF ANY CHANGES AND NOTE BELOW TO EXPLAIN:

- ☐ PARENTS MARITAL STATUS PARENT'S NAME
- ☐ FINANCIAL RESPONSIBILITY
- ☐ HOME ADDRESS
- ☐ PHONE NUMBERS / EMAIL ADDRESS
- ☐ DENTAL INSURANCE
- ☐ MEDICAL CONDITION
- ☐ ORAL HABITS
- ☐ HEART MURMUR
- ☐ SPEECH THERAPY
- ☐ CURRENT MEDICINES
- ☐ STAINED TEETH
- ☐ HOSPITALIZATION
- ☐ BROKEN TEETH
- ☐ CROOKED TEETH
- ☐ BEHAVIOR PROBLEMS
- ☐ MOUTH SORES / ULCERS

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In an effort to improve communications with our patients, Pediatric Dental Healthcare will be E-mailing and/or texting appointment reminders. If you are interested in being part of this service, please enter your information below. Please be aware that this email address may also be used to email you personal information (ie.Receipts,Invoices,Letters) relating to your dental care. Your information is only used for communications with you and other dental professionals. We do NOT share or sell personal information.

Personal E-mail: _____Mobile Phone#: _____

(Please Print Clearly) (Your Phone Provider May Charge a Texting Fee)

INFORMED CONSENT FOR PARENTS/GUARDIANS ACCOMPANYING THE CHILD

I hereby authorize the dentists and staff at Pediatric Dental Healthcare to perform diagnostic aids including an examination, x-rays, photographs, models, cleaning and fluoride treatment, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. (*Please cross out any treatment that you do not want performed.*) I authorize my insurance company to pay Pediatric Dental Healthcare all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment service charges. I also understand that obtaining insurance coverage and benefit information is my responsibility and not the responsibility of Pediatric Dental Healthcare. This consent is to remain in effect from the date indicated until cancelled in writing.

SIGNATURE RELATIONSHIP TO CHILD DATE

16 Washington Street (Rt.1) Plainville, MA 02762

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