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:

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