Marlborough Village
Pediatric Dental Care

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

1 Tell us about your child

Today's Date _____

Child's Name _____
LAST FIRST M. INITIAL

Child's Birthdate _____ Child's Age _____

Nickname _____ ☐ Male ☐ Female

School _____ Grade _____

Hobbies/Sports _____

Child's Home # _____ SS# _____

Child's Home Address _____

_____
CITY STATE ZIP

2 Who is accompanying this child today?

Name _____ Relation _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

List brothers /sisters with age _____

_____

General Dentist _____

Last Exam Date _____ Any Cavities? _____

Parent's Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

3 Parent's Information

Mother ☐ Step Mother ☐ Guardian

Name _____ Birthdate _____

Check which number is best to contact you.

☐ Home _____ ☐ Work _____ ☐ Cell _____

Employer _____

How long at your current job? ____ Job Title? _____

SS# _____ DL# _____

Email

Father ☐ Step Father ☐ Guardian

Name _____ Birthdate _____

Check which number is best to contact you.

☐ Home _____ ☐ Work _____ ☐ Cell _____

Employer _____

How long at your current job? ____ Job Title? _____

SS# _____ DL# _____

Email

4 Person Responsible for acount

Name _____ Relation _____

Billing Address _____

_____
CITY STATE ZIP

Previous Address _____

Hm# (___) _____ DL# _____

Employer _____

Wk# (___) _____ Ext. _____ SS# _____

Who is responsible for making appointments?

Name _____ Birthdate _____

Wk# (___) _____ Ext. _____ Hm# _____

Neighbor of relative not living with you

Name _____ Phone _____

Address _____

_____
CITY STATE ZIP

5 Primary Dental Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group# (Plan, local,or Policy#) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ S.S# _____

Policy Owners Employer _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone# _____

Group# (Plan, local,or Policy#) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ S.S# _____

Policy Owners Employer _____

All accounts sent to collections will be charged the account balance plus an additional 50%, based on the account balance.

6 Please share you main conerns

Has the child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra teeth permanent teeth? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMI/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician:_____

Phone#: _____ Date of last visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (girls) ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

Please list all drugs/things that the child is allergic to:

7 Please Indicate any medical conditions

Y N	Abnormal Bleeding	Y N	Handicaps/Disabilities
Y N	Allergies to any drugs	Y N	Hearing Impairment
Y N	Allergic to Latex/Medals	Y N	Heart Murmur
Y N	Allergic to plastics	Y N	Hemophilia
Y N	Any hospital stays	Y N	Hepatitis
Y N	Asthma	Y N	HIV+/ AIDS
Y N	Cancer	Y N	Kidney/ Liver Problems
Y N	Congenital Heart Defect	Y N	Rheumatic/Scarlet Fever
Y N	Convulsions/Epilepsy	Y N	Tuberculosis(TB)
Y N	Diabetes		

Please discuss any serious medical problems that the child has had: _____

8 Do any of the following concerns apply?

Y N	Clenching/Grinding Teeth	Y N	Nursing Bottle Habits
Y N	Lip Sucking/Biting	Y N	Speech Problems
Y N	Mouth Breather	Y N	Thumb/ Finger Sucking
Y N	Nail Biting	Y N	Tongue Thirst

9

I understand that the information that I have given is correct to the best of my knowledge, that it well be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and/or prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting agencies.

SIGNATURE OF PARENT OR GUARDIAN DATE

The parent or guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the parent/guardian & patient named herein.

Doctor's Comments Initials _____ Date _____