Child Health/Dental History Form

American Dental Association
www.ada.org

Patient's Name (LAST / FIRST / INITIAL)	Nickname	Date of Birth
Parent's/Guardian's Name	Relationship to Patient	
Address (PO OR MAILING ADDRESS / CITY / STATE / ZIP CODE)		
Phone (Home / Work)		Sex M ❑ F ❑

Have you (the parent/guardian) or the patient had any of the following diseases or problems? ❑ Yes ❑ No
1. Active Tuberculosis, 2. Persistent cough greater than a three-week duration, 3.Cough that produces blood?
If you answer yes to any of the three items above, please stop and return this form to the receptionist.

Has the child had any history of, or conditions related to, any of the following:

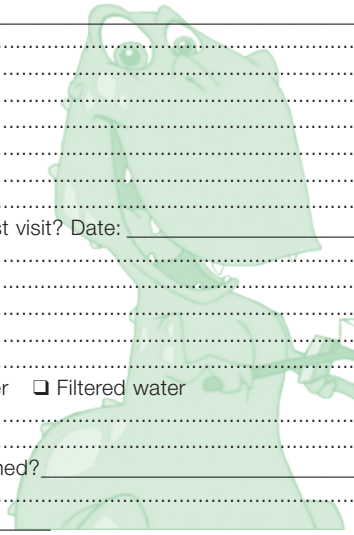
❑ Anemia	❑ Cancer	❑ Epilepsy	❑ HIV +/AIDS	❑ Mononucleosis	❑ Thyroid
❑ Arthritis	❑ Cerebral Palsy	❑ Fainting	❑ Immunizations	❑ Mumps	❑ Tobacco/Drug Use
❑ Asthma	❑ Chicken Pox	❑ Growth Problems	❑ Kidney	❑ Pregnancy (teens)	❑ Tuberculosis
❑ Bladder	❑ Chronic Sinusitis	❑ Hearing	❑ Latex allergy	❑ Rheumatic fever	❑ Venereal Disease
❑ Bleeding disorders	❑ Diabetes	❑ Heart	❑ Liver	❑ Seizures	❑ Other_____
❑ Bones/Joints	❑ Ear Aches	❑ Hepatitis	❑ Measles	❑ Sickle cell	

Please list the name and phone number of the child's physician:

Name of Physician _____ Phone _____

Child's History

		Yes	No
1.	Is the child taking any prescription and/or over the counter medications or vitamin supplements at this time? If yes, please list: _____	❑	❑
2.	Is the child allergic to any medications, i.e. penicillin, antibiotics, or other drugs? If yes, please explain: _____	❑	❑
3.	Is the child allergic to anything else, such as certain foods? If yes, please explain: _____	❑	❑
4.	How would you describe the child's eating habits? _____		
5.	Has the child ever had a serious illness? If yes, when: _____ Please describe: _____	❑	❑
6.	Has the child ever been hospitalized?	❑	❑
7.	Does the child have a history of any other illnesses? If yes, please list: _____	❑	❑
8.	Has the child ever received a general anesthetic?	❑	❑
9.	Does the child have any inherited problems?	❑	❑
10.	Does the child have any speech difficulties?	❑	❑
11.	Has the child ever had a blood transfusion?	❑	❑
12.	Is the child physically, mentally, or emotionally impaired?	❑	❑
13.	Does the child experience excessive bleeding when cut?	❑	❑
14.	Is the child currently being treated for any illnesses?	❑	❑
15.	Is this the child's first visit to a dentist? If not the first visit, what was the date of the last dentist visit? Date: _____	❑	❑
16.	Has the child had any problem with dental treatment in the past?	❑	❑
17.	Has the child ever had dental radiographs (x-rays) exposed?	❑	❑
18.	Has the child ever suffered any injuries to the mouth, head or teeth?	❑	❑
19.	Has the child had any problems with the eruption or shedding of teeth?	❑	❑
20.	Has the child had any orthodontic treatment?	❑	❑
21.	**What type of water does your child drink?** ❑ City water ❑ Well water ❑ Bottled water ❑ Filtered water		
22.	**Does the child take fluoride supplements?**	❑	❑
23.	**Is fluoride toothpaste used?**	❑	❑
24.	How many times are the child's teeth brushed per day? _____ When are the teeth brushed? _____	❑	❑
25.	Does the child suck his/her thumb, fingers or pacifier?	❑	❑
26.	At what age did the child stop bottle feeding? Age _____ Breast feeding? Age _____		
27.	Does child participate in active recreational activities?	❑	❑



NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Parent's/Guardian's Signature _____ Date _____

For completion by dentist

Comments _____

For Office Use Only: ❑ Medical Alert ❑ Premedication ❑ Allergies ❑ Anesthesia Reviewed by _____

Date _____

Form S707

To Reorder call 1-800-947-4746
or go online at www.adacatalog.org

Written Financial Policy

Thank you for choosing us for your dental needs. We promise to always offer you state of the art dentistry and the best preventative care. An important part of our mission is making the cost of optimal care as easy and manageable for our patients as possible by offering a choice of convenient payment options. Please read and sign the following:

Payment:
Payment is due in full at the time services are rendered.
You can choose from:

- Cash-Check- Visa- MasterCard-American Express- Discover
- Care Credit Financing-no interest payment plans (subject to credit approval)
    - 6 Months Deferred Interest for charges $200-$999.
    - 12 Months Deferred Interest for charges $1000 and above.

We offer a 10% courtesy accounting adjustment to non-insurance based patients who pay for their treatment with check or cash at the beginning of their dental care. (Not to be combined)

For those with dental insurance- the above policy is also adhered to on your first visit unless your benefits can be verified by our staff prior to, or by the time the services are rendered. For the first and any subsequent appointments we will collect your initial estimated portion and then bill the insurance company for the treatment. You will be responsible for any outstanding balance following insurance reimbursement.

Short Notice Cancellation & No Show Policy:
While emergencies sometimes do happen, kindly give us 24 hour notice if you must cancel or change your appointment. Without this advance notice, a fee of $50 could be charged to your account.

West Brookfield Dental requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

Overdue Balance:
We will send monthly statements to you if your account has an unpaid balance. After 90 days, if we have not received payment or been contacted to make financial arrangements you will be sent to the collection agency.

Returned Checks:
If a check is returned for any reason, there will be a service charge of $25.00 to cover administrative cost levied to us by the bank.

About your insurance benefits:
Our office is happy to cooperate with individuals who are covered by dental insurance. We only ask that you carefully read your policy to be sure that you are fully aware of any restrictions that may apply to the benefits provided. **Dental insurance is a contract between YOURSELF and the insurance company.** To fully utilize your yearly insurance benefits, please plan ahead. We encourage you to make your appointments early enough in the year to allow sufficient time to complete your treatment. Do not get caught in the year-end rush.

We have made a commitment to only provide the best care to our patients. We do stand behind our work and do what is right for our patients, but we can only do that if you also commit to taking care of your dental health after our work is done. You must commit to regular dental checkups at least 2 times a year and daily preventative home care. We cannot guarantee our work if you do not stay on a regular preventative routine care schedule or show signs of neglect to your oral health.

Consent & Authorization:
I have read and understand the financial policies of West Brookfield Dental. I understand that by receiving treatment for myself or for my dependents I authorize and accept responsibility to pay for such treatment. Fees not covered by my dental insurance will be promptly paid upon notification from this office. Without any reservations, I agree to abide by these policies.

_____
Name of Responsible Party, Parent, or Guardian

_____ _____
Signature **Date**

Please list all names of your dependents:

_____

_____

_____

_____

Agreement to Receive Electronic Communication

Patient Name:_____ Date of Birth:_____

(Initial below)

I ____ DO AGREE

I ____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial below)

____Text Messaging Cell Phone Number:_____

____ Email Email Address:_____

I would like to receive:

Appointment Reminders/Recall Visits

Information regarding insurance/billing

Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at anytime by calling:

West Brookfield Dental |508.867.2777| info@9-westmain.com

Patient/Guardian Signature: Date:

_____ _____

West Brookfield Dental

I, _____ have received a copy of the West Brookfield Dental Notice of Privacy Practice.

I give West Brookfield Dental my permission to confirm the date and time of all dental appointments; We will confirm on your home phone or cell phone unless otherwise notified.

PLEASE BE ADVISED THAT CONFIRMATION CALLS ARE A COURTESY TO OUR PATIENTS. IF WE ARE SHORT STAFFED OR OVERLY BUSY, WE MAY NOT HAVE TIME TO MAKE THESE CALLS. YOU WILL STILL BE RESPONSIBLE FOR YOUR APPOINTMENT.

West Brookfield Dental requires 24 hour notice for any appointment change. If 24 hour notice is not received; there will be a $50.00 charge. This charge is not a covered benefit by your insurance company and will be your responsibility. We will not be able to schedule future appointments until this charge is paid.

Patient, Parent, or Guardian: Date:

_____ _____

Dependents:

_____

_____

_____