Portland
CHILDREN'S DENTISTRY

# New Patient Information

## CHILD'S NAME:

1. First Name: ___________________________ Last Name: ____________________________________ M / F

   Preferred name: _______________________ DOB: ___________________ Date of Last Exam: _________________

2. First Name: ___________________________ Last Name: ____________________________________ M / F

   Preferred name: _______________________ DOB: ___________________ Date of Last Exam: _________________

3. First Name: ___________________________ Last Name: ____________________________________ M / F

   Preferred name: _______________________ DOB: ___________________ Date of Last Exam: _________________

**Name of child(ren)'s previous dentist:** ___________________________________________________________________

**How did you hear about our office?** _____________________________________________________________________

## RESPONSIBLE PARTY:

Relationship to patient(s): ☐ Parent ☐ Other: __________________________

First Name: _______________________________ Last name: ________________________________________

Mailing Address: __________________________________________________________

City ____________________ State _______ Zip ____________

DOB: ____________________________ SS# or Driver's License #: _____________________________________

Home #: ________________________ Work #: ________________________ Cell #: ___________________________

Email: __________________________________________________________

Other parent: ______________________________________________________

Emergency Contact: ___________________________ Relationship: ______________ Phone: ____________________

Do you prefer to be contacted by: ☐ Phone ☐ Email ☐ Text

## INSURANCE POLICY HOLDER:

First Name: _______________________________ Last: _____________________________________________

DOB: _______________________________ Employer: ________________________________________

Insurance: ___________________________________________________________________

Insurance ID: ___________________________ Group #: __________________________

Do you have secondary insurance coverage? ☐ Yes ☐ No

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# *Medical History*

Patient Name: ___________________________ Birth Date: ___/____/_____ Today's Date: ___/____/_____

**It is important for your child's dentist to have a thorough understanding of your child's medical history. Medications or health issues may have an impact on your child's treatment. Thank you for taking the time to fill out this form completely.**

| Question | | | | |
|---|---|---|---|---|
| What is the name of your child's pediatrician? | | | | ________________________________ |
| Was your child born prematurely? | □ Yes | □ No | If yes, how many weeks? | ________________________________ |
| Has your child ever been hospitalized, had an operation, or been sedated for a procedure? | □ Yes | □ No | If yes, please explain | ________________________________ |
| Has your child ever had a serious injury to the head, neck, or teeth? | □ Yes | □ No | If yes, please explain | ________________________________ |
| Is your child taking any medications, including vitamins or supplements? | □ Yes | □ No | Please list: | ________________________________ |
| Does your child have any allergies? | □ Yes | □ No | Please list: | ________________________________ |
| Does your child take antibiotics prior to dental procedures? | □ Yes | □ No | If yes, please explain | ________________________________ |
| Are your child's vaccinations up to date? | □ Yes | □ No | | |

Does your child have, or has he/she had, any of the following? Please check all that apply:

| | | | |
|---|---|---|---|
| □ Anaphylaxis | □ Anemia | □ Artificial joint/Implanted device | □ Asthma or breathing problems |
| □ Autoimmune disease | □ Bleeding disorder, bruising, hemophilia | □ Cancer/Leukemia | □ Cold sores/Fever blisters |
| □ Cortisone or steroid medicine | □ Diabetes | □ Epilepsy or seizures | □ Fainting spells/Dizziness |
| □ Heart condition or murmur | □ Hepatitis | □ HIV/AIDS | □ Kidney problems |
| □ Latex allergy | □ Learning disability, delay, or sensory issue | □ Liver disease | □ Rheumatic fever |
| □ Sickle cell disease | □ Snoring/Obstructive sleep apnea | □ Spina bifida | □ Stomach/GI disease |
| □ Thyroid disease | □ Tuberculosis | | |

Has your child had any condition not listed above: □ Yes □ No. If Yes, please explain: ________________________________

If you answered yes to any of the questions above, please explain: ________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Is there any additional information about your child's health that you feel we should know when treating your child?

______________________________________________________________________________

______________________________________________________________________________

**To the best of my knowledge, the answers on this form are accurate. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in medical status.**

________________________________ ___/____/_____

Signature of parent/guardian Date

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# Dental History

Patient name: ______________________________

**Your child's previous experience at the dentist can have a significant impact on the care he or she receives at Portland Children's Dentistry. Thank you for taking the time to complete this form**

What brings you and your child to Portland Children's Dentistry today?

Has your child ever been examined by a dentist? □ Yes □ No. If yes, when was he/she last seen: ______________________________

If yes, was your child's experience:

□ Positive □ Negative □ Neutral

What is your child's attitude towards today's visit?

□ Shy □ Nervous □ Excited

| | | | | |
|---|---|---|---|---|
| Does your child have any oral habits (thumb sucking, pacifier, mouth breathing, etc.) | □ Yes | □ No | If yes, please explain: | ________________ |
| Has your child ever had an orthodontic appliance or braces? | □ Yes | □ No | If yes, please explain: | ________________ |
| Does your child live in a community with a fluoridated water supply? | □ Yes | □ No | | |
| Does your child take a fluoride supplement? | □ Yes | □ No | If yes, please explain: | ________________ |
| How often does your child brush his/her teeth? | ________________ | | | |
| What type of toothpaste does your child use? | ________________ | | | |
| Does your child floss? | □ Yes | □ No | | |
| Is your child's brushing/flossing supervised by an adult? | □ Yes | □ No | | |
| Is your child nursing? | □ Yes | □ No | | |
| Does your child use a bottle or sippy cup? | □ Yes | □ No | If yes, what is in it? | ________________ |

What are your child's typical snacks and drinks? How frequently does he or she get these snacks?

________________________________ ___/___/_____
Signature of parent/guardian Date

## FINANCIAL POLICIES

**Portland Children's Dentistry** will work hard to find a financial plan that works for your family. We accept several forms of payment for dental treatment including cash, debit card, personal check, business check, Care Credit, and credit card.

***Dental Insurance***: Our office works with many insurance companies. We will work with you and your insurance company to help you understand and maximize your benefits. We will answer your questions to the best of our ability. Please become familiar with your policy and understand its coverages, exclusions, deductibles, and maximums.

As a courtesy, we will file your claims promptly and follow American Dental Association guidelines for claims and coding. It is important to understand that our office will estimate your benefits to the best of our ability. Many insurance companies will not provide us with detailed information about your family's coverage, so any insurance figures that we provide are only estimates.

***As the insured patient/parent and/or owner of the policy,*** your responsibilities include:

- paying all fees not estimated to be covered by insurance at the time of treatment.
- assuming responsibility for any amounts expected from your insurance company but not received within 30 days after treatment has been performed and the claim is submitted.

I hereby authorize Portland Children's Dentistry, LLC to release to my insurance company any information acquired in the course of my dental care. I authorize benefits to be paid directly to Portland Children's Dentistry, LLC. I understand that I am responsible for all fees incurred, *regardless of status of insurance*. I understand that treatment cannot be completed until it is paid for (i.e. Space maintainers).

Responsible party: ______________________________

________________________________________________ ________________________

Signature Date

Name of family members covered by this agreement: ____________________________________________

______________________________________________________________________________________________

*** Portland Children's Dentistry will apply $3 service fee for outstanding balances of 60 days or more.

*** Returned checks will be assessed a fee of $30.