COASTAL MAINE Pediatric Dentistry

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We look forward to working together toward your child's oral health!

Patient Information

Name ____ **DOB** _____/_____/______

Is there a nickname we could use to make you child feel more comfortable? ______________________

Responsible party contact information:

Street ______________________________ **City** ________________ **Zip** __________

Home Phone ________________ **Cell Phone** ________________ **Text Message Appt Reminders: Y / N**

E-mail ____ **E-mail Message Appt Reminders: Y / N**

Insurance Information

Some of the services our office provides may be covered by your medical insurance. Please present all insurance cards for convenient billing directly to your insurance provider. If your child is not covered by dental insurance, please circle here: **N/A***

DENTAL Policy Holder ______________________________ **Policy Holder DOB** _____/_____/______

Employer ____________________ **Insurance Company** ____________________

Group Number ____________________ **ID Number** ____________________

MEDICAL Policy Holder ______________________________ **Policy Holder DOB** _____/_____/______

Employer ____________________ **Insurance Company** ____________________

Group Number ____________________ **ID Number** ____________________

(OTHER) Policy Holder ______________________________ **Policy Holder DOB** _____/_____/______

Employer ____________________ **Insurance Company** ____________________

Group Number ____________________ **ID Number** ____________________

MaineCare ID ____

I authorize my insurances to pay directly to my dentist. I understand that all insurance policies are different and I am responsible for knowing my plan provisions. I understand I will be responsible for all co-payments, deductibles, and rejected charges. ***I understand that if my child is not covered by dental insurance, I am responsible for all payments due on the date of service.**

Signature ______________________________ **Date** ____________________

Referral Information

It is very important to our practice to properly thank patients, doctors, and those in our community who have shared their positive experience with you. We hope to see your name added to our growing list of happy patients who refer our practice to friends and family looking for a caring dental home!

☐ Friend or Family Member (name, please) ______________________________

☐ Sibling is/was a patient in our practice ☐ Search Engine (please specify) ____________________

☐ Facebook ☐ Other ______________________________

***PLEASE FILL OUT MEDICAL HISTORY ON THE BACK.**

Medical History

We appreciate as much detail as possible so we may best serve the individual needs of your child.

☐ **Yes** ☐ **No** Does your child have a primary care physician? Name ____________________

Phone ____________________ Date of last exam ____________________

☐ **Yes** ☐ **No** Is your child currently taking any medications? Please give medication, dose, and reason: ____________________

____

☐ **Yes** ☐ **No** Does your child have any allergies?____________________

☐ **Yes** ☐ **No** Any hospitalizations/ Emergency Room visits? ____________________

____

Please check if your child has been diagnosed or treated for any of the following:

☐ ADD/ADHD
☐ AIDS/HIV
☐ Anemia
☐ Asthma
☐ Autism
☐ Blood Disorder/Transfusion
☐ Cancer/ Tumors
☐ Cerebral Palsy
☐ Cleft Lip/ Palate
☐ Congenital Birth Defects
☐ Developmental Delays
☐ Diabetes
☐ Epilepsy/ Seizures
☐ Excessive Bleeding
☐ Frequent Headaches
☐ Heart Condition/ Murmur
☐ Hepatitis
☐ Kidney Disease
☐ Liver Disease
☐ Rheumatic Fever
☐ Speech/ Hearing Problems
☐ Stomach/ GI Disease
☐ Tuberculosis
☐ Other: ____________________

Please provide further detail on any items checked ____________________

____

Are there any dental concerns you would like to discuss? ____________________

____

How do you feel your child will react to dental treatment? ____________________

Was your child ☐ **breast fed** ☐ **bottle fed** At what age was it stopped? ____________________

☐ **Yes** ☐ **No** Has your child ever been to a dentist? Date of last visit ____________________

Name of dentist ____________________

☐ **Yes** ☐ **No** Has your child ever had dental x-rays? Date of most recent ____________________

☐ **Yes** ☐ **No** Has your child ever injured his/her teeth? Explain: ____________________

____

☐ **Yes** ☐ **No** Does/did your child suck on: ☐ **fingers** ☐ **thumb** ☐ **pacifier** Age stopped? ____________________

☐ **Yes** ☐ **No** Does your child brush their teeth? How often? ____________________ Do you help? ☐ **Yes** ☐ **No**

☐ **Yes** ☐ **No** Does your child floss? How often? ____________________ Do you help? ☐ **Yes** ☐ **No**

☐ **Yes** ☐ **No** ☐ **Unknown** Is your water at home fluoridated? ☐ **town water** ☐ **well water** ☐ **other:** ____________________

☐ **Yes** ☐ **No** ☐ **Unknown** Does your child use fluoride toothpaste?

☐ **Yes** ☐ **No** ☐ **Unknown** Does your child take a fluoride supplement? Prescribed by: ____________________

☐ **Yes** ☐ **No** Snacks or beverages are consumed between meals. If **Yes**, how many times a day are snacks consumed: ____________________

Type of snack/beverage: ____________________ /____________________

☐ **Yes** ☐ **No** **(children 4 and under)** Liquids other than water are given in crib/bed by bottle/sippy cup or available continuously during the day in a bottle/sippy cup. If **Yes**, type of beverage:____________________

☐ **Yes** ☐ **No** **(children 4 and under)** Parent or caregiver has had a cavity within the last 12 months.

Registration completed by (print): ____________________ Relationship to patient:____________________

Signature ____________________ **Date** ____________________