



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 _____

(OTHER) Policy Holder _____ Policy Holder DOB ____/____/____

Employer _____ Insurance Company _____

Group Number _____ ID Number _____

Yes No MY CHILD HAS MAINECARE 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:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Cancer/ Tumors | <input type="checkbox"/> Epilepsy/ Seizures | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cleft Lip/ Palate | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Speech/ Hearing Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Congenital Birth Defects | <input type="checkbox"/> Heart Condition/ Murmur | <input type="checkbox"/> Stomach/ GI Disease |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Developmental Delays | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Blood Disorder/Transfusion | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> 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** _____