COASTAL MAINE Pediatric Dentistry

84 Baribeau Drive
Brunswick, ME 04011
207-607-4197
www.coastalmainepediatricdentistry.com

Patient Name _____ **DOB** _____/_____/_____

CHANGES TO RESPONSIBLE PARTY CONTACT INFORMATION? ☐ **No** ☐ **Yes (update on back)**

CHANGES TO INSURANCE INFORMATION? ☐ **No** ☐ **Yes (update on back by listing current insurance)**

Medical and Dental Update and Caries Risk Information

☐ **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 since your last dental visit? _____

_____

☐ **Yes** ☐ **No** Are there any family changes or recent diagnoses that may affect your child's health **or** general wellbeing? _____

_____

☐ **Yes** ☐ **No** Are there any dental concerns you would like to discuss? _____

_____

CARIES RISK INFORMATION:

☐ **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)** Mother or caregiver has had a cavity within the last 12 months.

☐ **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: _____

Updated registration completed by (print): _____ Relationship to patient: _____

Signature _____ **Date** _____

Thank you for helping us keep our records updated so we can provide you and your child with the best oral healthcare experience.

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 no longer 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 _____