CHILD'S INFORMATION AND HEALTH HISTORY

INITIAL EXAM DATE _____

CHILD'S NAME _____ DATE OF BIRTH _____
(NICKNAME IF ANY)

CHILD'S ADDRESS _____ CHILD'S PHONE _____

HOBBIES, SPORTS AND INTERESTS _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RESIDENCE PHONE _____

RESIDENCE ADDRESS _____

EMPLOYED BY _____ BUSINESS PHONE _____

BUSINESS ADDRESS _____ SS # _____

DENTAL INSURANCE PLAN (IF ANY) _____ REFERRED BY _____

PATIENT'S NAME

DENTAL HISTORY

CHIEF ORAL COMPLAINT _____

DATE OF LAST DENTAL EXAM. _____ ANY PREVIOUS UNFAVORABLE DENTAL EXPERIENCE, ☐ YES ☐ NO EXPLAIN _____

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Traumatic injury to mouth or teeth
- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long _____
- ☐ Food impaction
- ☐ Clenching or grinding of teeth
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on lips or mouth
- ☐ Pain around ear
- ☐ Bad breath
- ☐ Complications from extractions
- ☐ Topical Fluoride Treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Oral habits; thumbsucking, fingernail biting, cheek biting, etc.
- ☐ Texture of toothbrush _____
- ☐ Frequency of brushing _____
- ☐ Dental Floss
- ☐ Disclosing tablets or solution
- ☐ Fluoride supplements
- ☐ Between meal snacks
- ☐ Well balanced diet

MEDICAL HISTORY

PHYSICIAN'S NAME _____ DATE OF LAST PHYSICAL EXAM. _____ CHILD'S AGE _____

DOES THE CHILD HAVE OR HAS THE CHILD HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

- ☐ Allergy to Penicillin
- ☐ Allergies to other drugs
- ☐ Allergies to anesthetics
- ☐ Any heart ailments
- ☐ Radiation Treatments
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia or blood problems
- ☐ Asthma
- ☐ Hay fever or allergies in general
- ☐ Diabetes
- ☐ Kidney problems
- ☐ Liver problems or hepatitis
- ☐ Malignancies or Leukemia
- ☐ Psychiatric care/emotional problems
- ☐ Rheumatic fever
- ☐ Immune System Disorders (AIDS, HIV, ARC)
- ☐ Sinus problems
- ☐ Physical or mental handicap
- ☐ Thyroid disorders
- ☐ Eye disorders
- ☐ Tonsillitis
- ☐ Ulcer or colitis
- ☐ Extreme nervousness or apprehension
- ☐ Other _____

Describe any current medical treatment including drugs taken, even though not listed above _____

APPOINTMENTS: A minimum charge will be made for failed or cancelled appointment without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for the patient.

INSURANCE: To avoid misunderstanding regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged directly to them and that they are personally responsible for payment of fees. We will prepare necessary forms or reports to help the persons responsible to obtain benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

SIGNATURE _____ DATE _____
PARENT OR GUARDIAN

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Full Name: _____

Address: _____ Date of Birth: _____

_____

This Authorizes: Downeast Pediatric Dentistry PLLC
888 Brighton Ave
Portland, ME 04102

TO PROVIDE INFORMATION SPECIFIED TO:

_____
Physician / Provider or Company / Person / Facility

☐ **VIA EMAIL (only Procedure History and Rads)** :_____

☐ **VIA US MAIL** – $25.00 Duplication Fee (we will contact you for payment)
ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INFORMATION TO BE RELEASED

Please select the information to be released from the list below. (Specify Dates of Treatment) From _____ to _____

☐ The Following Medical records:
- ☐ Digital Procedure History and treatment plan form(s) ☐ Progress Notes – $25 Duplication Fee
- ☐ Digital X-ray Images

☐ PLEASE RUSH THIS REQUEST FOR DEIGITAL RECORDS (48 Hour Turnaround) $25 FEE APPLIES

REQUESTS TO MAIL RECORDS WILL INCUR A $25 DUPLICATION DOLLAR FEE

REQUESTS TO EMAIL XRAY IMAGES AND PROCEDURE HISTORY WILL NOT INCUR A FEE

REVOCATION: I understand that I may revoke this authorization at any time by sending a written notice to Downeast Pediatric Dentistry PLLC. However, the revocation will not have any effect on the disclosure the Downeast Pediatric Dentistry PLLC may have made before the revocation was received.

EXPIRATION: I understand that unless I revoke the authorization earlier, this authorization will automatically expire ninety (90) days from the date with authorization is signed.

REDISCLOSURE: I understand that information used or disclosed in accordance with the authorization may no longer be protected by federal law and could be redisclosed to third party.

REFUSAL TO SIGN: I understand that I may refuse to sign this authorization, and Downeast Pediatric Dentistry PLLC will not condition treatment on whether I sign this authorization.

CERTIFICATION: I certify, I am the authorized representative of the patient, and the identification and the proof or authority I have provided are true and correct.

My relationship to the patient is that of: _____

Signed this _____ day of _____ , 20____

Signature: _____ Print Name: _____

RETURN COMPLETED FORM TO – RECORDS@DOWNEASTPEDS.COM OR FAX TO 207-761-6953
PLEASE ALLOW UP TO 3 WEEKS FOR PROCESSING