

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 _____

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 (✓)

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

MEDICAL HISTORY

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

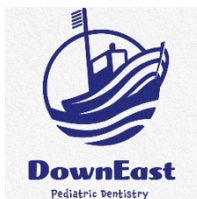
DOES THE CHILD HAVE OR HAS THE CHILD HAD ANY OF THE FOLLOWING - INDICATE WITH A (✓)

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



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.

REDISCLASURE: I understand that information used or disclosed in accordance with the authorization may no longer be protected by federal law and could be rediscovered 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