Braintree Pediatric Dental Associates

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400 Washington St. #301
Braintree, MA 02184

Patient Information

Name of Child **Date of Birth:**
Address **Phone #**
Parent Name **Soc. Sec. #**
Address/Phone No
Employer **Work/Cell Phone #**
Parent Name **Soc. Sec. #**
Address/Phone No. **Work/Cell Phone #**
Person Financially Responsible
Dental Insurance Co.
Physician Name _______________ **Address/Phone No**___________________________

Health History

Does your child go to daycare or school? ……………………………………………………….Yes/No
Does your child have a dental problem today? ....Yes/No
Is a physician treating your child now? Please explain…………………………..……..….…Yes/No
Is your child taking any medication now, incl. Fluoride? Please explain……..……....…....Yes/No
Is your child allergic to any medicine or food? Please explain……………….………..…...Yes/No
Has your child ever bled excessively from a cut? Please explain………………..……..……Yes/No
Has your child ever been hospitalized? For what reason and when?………………..……...Yes/No
Does your child have a history of or difficulty with any of the following? Please circle.

Abuse	Autism	Diabetes	Heart Problems
Thyroid Problems	AIDS/HIV	Bleeding Problems	Down's Syndrome
Kidney Disease	Tuberculosis	Allergies	Cancer
Epilepsy	Learning Problems	Anemia	Cerebral Palsy
Fainting	Liver Disease	Asthma	Developmental Delay
Hearing Problems	Intellectual Disability	None of the above	

Other ____

Emergency Contact

In case of emergency, whom shall we contact?
Name
Phone

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my child's medical status.

____ _______________________
Signature of Parent/ Legal Guardian Date

I certify that my child is covered by insurance with ____________________________________ and assign directly to Braintree Pediatric Dental Associates all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____ _______________________
Signature of Parent/ Legal Guardian Date