Does your child have a specific dental concern today? Yes ☐ No ☐

If yes, describe ______________________________

____

____

Does your child on a routine basis:
(check all that apply): Brush ☐ Floss ☐

Do your child's gums bleed? Yes ☐ No ☐

Does your child Smoke or Chew tobacco? Yes ☐ No ☐

Is your child's mouth...

☐ Very Comfortable
☐ Moderately comfortable
☐ Uncomfortable

Are you happy with the appearance or the color of your child's teeth? Yes ☐ No ☐

Is there anything else that we should include in your child's patient records:

____
____
____
____
____
____
____
____
____

PERSON TO CONTACT IN CASE OF EMERGENCY

Name: ______________________________

Address: ______________________________

____

Phone #: ______________________________

Secondary Emergency Contact:

Name: ______________________________

Address: ______________________________

____

Phone #: ______________________________

FINANCIAL POLICY

As you may know, your dental insurance does not always cover the cost of your treatment. In these instances, you may be financially responsible for your treatment. To keep our fees to you as low as possible, we ask that you pay your co-payment at the time you receive treatment. Please indicate the method you intend to use to pay for your dental treatment, including your co-payment:

☐ Credit Cards ☐ Checks ☐ Cash

☐ I would like to know more about financing my treatment

____

Signature of ☐ Patient or ☐ Guardian

For Patients with Insurance

By signing below I hereby authorize this office to affix my name to any and all claims or documents as related to any and all health benefits due to me and my dependents through my employment. I hereby authorize payment of dental benefits otherwise payable to me, directly to this dental office. This "Signature on File" will be valid from this date and shall expire in one year or unless I cancel the authorization through written notice to this office. A photocopy of this document may act as an original. Please understand this account is still your responsibility.

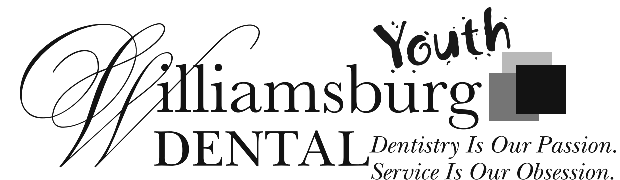
____

"Signature on File" Effective Date

NOTICE

Balances over 60 days old are subject to an interest charge of 1.5% per month (annual rate 18%)

Thank You for completing this Patient Information Form!



Getting to know you!

☐ Dr. Joseph Capista
☐ Dr. Joseph Lamb
☐ Dr. Robert Spennato
☐ Dr. Daniel Tibbetts

Today's Date: ______________________________

Name: ______________________________

Nickname: ______________________________

Address: ______________________________

____

City: ______________ St: ____ Zip: ________

Telephone numbers:

Home: ______________________________ ☐ best

Other: ______________________________ ☐ best

Date of Birth: ______________________________

School: ______________________ Grade: ___

Whom may we thank for referring you to our office:

☐ I saw your sign ☐ Yellow pages

☐ My Friend ______________________________

☐ My Family ☐ Advertisement

Who will be responsible for your financial arrangements?

Name: ______________________________

For Primary Insurance Purpose

Insured's Name: ______________________________

Relationship: ______________________________

Employer: ______________________________

Insurance carrier: ______________________________

Group Number: ______________________________

Insured's Date of birth:

____

Insured's SS#: ______________________________

Thank You!

Dental / Medical History

(Please ask your child the following questions)

	Yes	No
Are your teeth sensitive to		
Heat?	☐	☐
Cold?	☐	☐
Sweets?	☐	☐
Biting Pressure?	☐	☐
Does food catch between your teeth?	☐	☐
Do your gums bleed when brushing?	☐	☐
Have you noticed any swelling around any teeth?	☐	☐
Do you ever avoid any part of the mouth while brushing?	☐	☐

Where? ______________________________

	Yes	No
Are you dissatisfied with your teeth and their appearance?	☐	☐
Do you get frustrated because you always have something to be treated or repaired when you visit a dentist?	☐	☐
Do you want to learn to control dental disease and retain your teeth?	☐	☐
Do you have an unpleasant taste or odor in your mouth?	☐	☐
Do you smoke?	☐	☐
Have you ever had any teeth removed?	☐	☐

How long have these teeth been missing?

☐ Recently ☐ ____________________ago

When was your last set of x-rays? ______________

When was your last dental appointment?

Approximate date: __________________________

	Yes	No
Have you ever had a reaction to local anesthetic?	☐	☐
Do you have any general health problems?	☐	☐

If so, please specify ___________________________

____

	Yes	No
Have you ever had Surgery?	☐	☐

If so, please specify ___________________________

____

	Yes	No
Are you currently under a physician's care?	☐	☐

Reason: ____________________________________

____

____

	Yes	No
Are you taking <u>any</u> medications at this time?	☐	☐

If so, please specify ___________________________

____

____

To the best of your knowledge, are you or have you ever been affected with:

	Yes	No
Heart Murmur/MVP	☐	☐
Heart Ailment	☐	☐

If so, please specify ___________________________

____

	Yes	No
Asthma	☐	☐
Diabetes	☐	☐
Rheumatic Fever	☐	☐
High Blood Pressure	☐	☐
Respiratory Disease	☐	☐
Hepatitis Type: _______________	☐	☐
Prolonged Bleeding	☐	☐
Healing Complications	☐	☐
Allergy to any Drugs	☐	☐

If yes, please specify: __________________________

____

____

	Yes	No
Are you Pregnant?	☐	☐

Month _______

	Yes	No
HIV / AIDS	☐	☐

Why did you leave your last dentist?

____

What are your present dental problems?

____

____

To the best of my knowledge, all of the proceeding answers are correct. If I have any changes in my health status or if my medicines change, I shall inform the dentist and/or staff at the next appointment without fail. I hereby authorize the dental office to administer such medication and perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I grant the right of the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health care professionals.

Responsibility & Consent Statement:

I give my consent to any advisable and necessary dental procedures, medications, or anesthetics to be administered by the attending dentist or by his supervised staff for diagnostic purposes of for dental treatment for the child named above in my absence.

____

Signature of ☐ Patient or ☐ Guardian Date

Dental / Medical History Update

My information has changed in the following way:

	Yes	No
Any Medications:	☐	☐

Specify: ___________________________________

____

____

	Yes	No
New Allergies:	☐	☐

Specify: ___________________________________

____

	Yes	No
Physical Health / Hospitalization	☐	☐

Specify: ___________________________________

____

	Yes	No
Other	☐	☐

Specify: ___________________________________

____

Address: ___________________________________

____

Phone #: ☐ Home ____________________________

☐ Other:____________________________

To the best of my knowledge, the updated answers are correct. I will continue to notify the office of any changes in my health status or if my medicines change without fail.

____

Signature of ☐ Patient or ☐ Guardian Date