ARTHUR A. DANIELS D.D.S. M. S.c.D. P.C.
DIPLOMATE, AMERICAN BOARD
OF PEDIATRIC DENTISTRY

174 LOWELL STREET
ANDOVER, MA 01810
TELEPHONE: 978-474-0082

CHILD REGISTRATION AND HISTORY

Child's Name____ Nickname________________

First Middle Last

Sex ☐ Male ☐ Female Birthday ______________ Age__________ School ______________________ Grade__________

Siblings that we treat ____

Is this your child's first dental visit? ☐ Yes ☐ No Is this an emergency visit: ☐ Yes ☐ No

Name of former Dentist? ______________________ Date of last visit ____________Any X-Rays Taken?______________

Has your child had any bad past dental experiences? ☐ Yes Explain ______________________________________

Please check any of the following that may describe your child:

☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Defiant

☐ Suspicious ☐ Moody ☐ High Strung ☐ Regular Kid ☐ Friendly ☐ Cooperative

Name of child's pet ____________________ Favorite interest ____________________ Favorite Sport ____________________

How do you expect your child to react to their visit today? ☐Excellent ☐Good ☐Fair ☐Poor ☐Don't Know

How may we help to make this a positive experience for your child? ________________________________

Name of family dentist ____

Whom may we thank for referring you to our office? ____

MEDICAL INFORMATION

Child's Pediatrician____ Date of last physical? ______________________

Address ____ Phone ______________________

	Y	N
Is your child in good health?	☐	☐
Are your child's immunizations up to date?	☐	☐
Is your child being treated for any condition presently?	☐	☐
If so, explain ______________________________		
Is your child taking any medications?	☐	☐
If so, explain ______________________________		
Has your child ever been hospitalized or had surgery?	☐	☐
If so, explain ______________________________		
Does your child have any allergies or reactions to any medications?	☐	☐
If so, explain ______________________________		

Does your child have any allergies to the following?

☐ Latex ☐ Food ☐ Food Dyes ☐Other ______________________________________

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

Y	N		Y	N		Y	N	
☐	☐	AIDS	☐	☐	Chronic Adenoid/Tonsil Infections	☐	☐	Handicaps/Disabilities
☐	☐	Anemia	☐	☐	Chronic Ear Infections	☐	☐	Hearing Impairment
☐	☐	Asthma	☐	☐	Cleft Lip/Palate	☐	☐	Heart Problems
☐	☐	Autism	☐	☐	Diabetes	☐	☐	Hemophilia
☐	☐	Birth Defects	☐	☐	Epilepsy/Convulsions	☐	☐	Hepatitis
☐	☐	Brain Injury	☐	☐	Excessive Bleeding	☐	☐	Hyperactivity
☐	☐	Bruises Easily	☐	☐	Fainting/Dizziness	☐	☐	Kidney/Liver Problems
☐	☐	Cancer	☐	☐	Growth & Development Problems	☐	☐	Leukemia
☐	☐	Cerebral Palsy						

Please describe any other condition that we should be aware of.______________________________________

DENTAL INFORMATION

	Y	N	
Was your child bottle fed?	☐	☐	If yes, until what age ______________________
Was your child breast fed?	☐	☐	If yes, until what age ______________________
Has our child ever had any injuries to his teeth, mouth, head or jaws?	☐	☐	If yes, describe ___________________________
Does your child brush daily?	☐	☐	
Does an adult assist with the brushing?	☐	☐	
Does your child floss daily?	☐	☐	
Does an adult assist with the flossing?	☐	☐	

Does your child have any of the following mouth habits?

☐ Finger Sucking ☐ Thumb Sucking ☐ Pacifier ☐ Tongue Thrusting ☐ Lip Sucking ☐ Mouth Breather ☐ Teeth Grinder

Does your child receive fluoride in any of the following forms?

☐ Vitamins ☐ Water supply ☐ Toothpaste ☐ Rinse/Gel ☐ Tablets/Drops Dosage: mg/day

GENERAL INFORMATION

Father's Full Name ____

Address____

City _________________________ State ___________ Zip __________

Home Phone ________________ Cell Phone ______________________

S.S # ____________________________ Birthday __________________

Employed by ____

Occupation ____________________ Work Phone ________________

Mother's Full Name ____

Address ____

City __________________________ State __________ Zip ________

Home Phone __________________ Cell Phone __________________

S.S # __________________________ Birthday __________________

Employed by ____

Occupation ____________________ Work Phone ________________

Child lives with ☐ Both Parents ☐ Mother ☐ Father ☐ Other _________________________________

PATIENTS COVERED BY DENTAL INSURANCE

Primary Carrier

Subscriber Name ____

ID Number ____

Group Number ____

Employer Name ____

Insurance Company ____

How long have you had this insurance coverage? ________________

Secondary Carrier

Subscriber Name ____

ID Number ____

Group Number ____

Employer Name ____

Insurance Company ____

How long have you had this insurance coverage? ________________

In order to comply with most insurance companies, we ask that you sign below so that we may keep your signature on file.

I have reviewed the following treatment plan. I authorize the release of any information relating to claims.

I hereby authorize and direct payment of the dental benefits to Dr. Arthur A. Daniels.

Signed ____ Date ______________________________

FINANCIAL INFORMATION, TERMS AND CONDITIONS

Please provide us with one of the following:

VISA, # ____

MasterCard, # ____

American Express, # ____

Discover, # ____

Expiration Date ______________ Bank of Credit Card _______________________________________Cardholder Names _______________________________

The Parent or Guardian who accompanies the child is responsible for payment at the time of service.

As a condition of treatment by this office, all fees for private accounts must be paid at the time the service is performed. Payment may be by cash, check, or credit card. Any other payment arrangement must be authorized by the office manager in advance. Any account balance 60 days old will be charged to the credit card you have provided above. Any other financial arrangement is subject to a service charge of 1 1/12% per month (18% per year) on the unpaid balance.

For patients who carry dental insurance, similar terms apply. This office will accept assignments of benefits based on our ability to charge your credit card for patient deductibles and for any portion of the treatment fee not covered by your insurance benefits. Any insurance payment not received in 60 days from date of service will be charged to your credit card. We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims.

Fees estimated for proposed dental services are honored for a period of 60 days from date of patient examination.

There will be a $50 fee per patient for anyone that does not cancel with at least a 24 hour advanced notice, or does not show up for their appointment. In an effort for us to reach you during the day to confirm, we need a current home or cell phone number to confirm an appointment and avoid us from having to leave a message on your voicemail. It is not fair to us, or to the patient who could have had an appointment, that someone else did not keep. When a charge of $50 has been applied to an account, all other appointments will be cancelled and no more appointments will be made until the charge is paid.

In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services and agree to pay all costs and reasonable attorney fees incurred by my failure to remit for services rendered. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions of treatment and agree in content.

Signed ____ Date ______________________________