NORTH SHORE
PEDIATRIC DENTAL
& ORTHODONTICS

DR. LISA CAMPANELLA
900 CUMMINGS CENTER, STE 116-T
BEVERLY, MA 01915
PHONE: 978-236-1188
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PATIENT INFORMATION

Date: _____

First Name _____ Last Name _____ Middle _____

Nickname: _____ Birth Date ____/____/____ Gender: □ Male □ Female

Address _____

(Street) (City) (State) (Zip)

School _____ Grade _____ Hobbies/Sports _____

Home Phone _____ Cell Phone _____ Email _____

Siblings (Name and Age) _____

Do you have any issues or concerns regarding your child's dental health? _____

Has your child had any negative dental experiences? _____

Name of family dentist: _____

HOW DID YOU HEAR ABOUT US? Please check all that apply

□ Dentist □ Friend □ Relative □ Website □ Facebook □ Newspaper □ Internet Search

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

Other adults we should know about that may bring your child to appointments: Phone Number _____

Last Name _____ First Name _____ Relationship: _____

Are we allowed to share appointment, treatment, and financial information with this person? □ Yes □ No

DENTAL INFORMATION

	YES	NO
Was your child bottle fed?	☐	☐
If yes, until what age? _____		
Was your child breast fed?	☐	☐
If so, until what age? _____		
Has your child ever had any injuries to their teeth, mouth, head or jaw?	☐	☐
If yes, please describe _____		
Does your child brush 2x per day?	☐	☐
Does an adult assist with the brushing/flossing?	☐	☐

Does your child have any of the following mouth habits?
☐ Finger Sucking ☐ Thumb Sucking ☐ Tongue Thrusting ☐ Lip Sucking ☐ Mouth Breathing ☐ Teeth Grinding ☐ Other

Does your child receive fluoride in any of the following forms?
☐ In Vitamins ☐ In water supply ☐ In Toothpaste ☐ In Rinse/Gel ☐ In Tablets/Drops

Please check any of the following that may describe your child:
☐ Outgoing ☐ Cooperative ☐ Shy ☐ Anxious ☐ Moody ☐ Stubborn ☐ Trusting ☐ Friendly ☐ Defiant

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

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

MEDICAL HISTORY

PATIENT NAME:_____ DATE:_____

Physician_____Phone Number_____ Date of last visit_____

Is your child in good health?	Yes No
Are your child's immunizations up to date?	Yes No
Is your child being treated for any condition presently?	Yes No
If so, please explain:_____	
Has your child ever been hospitalized or had surgery?	Yes No
If so, please explain:_____	

MEDICATIONS [ ] Not currently taking any medications

Please list current medications including over the counter products _____

_____

ALLERGIES [ ] No History of Allergies

Please check if you are allergic to any of the following: [ ] Dental Anesthetics [ ] Latex [ ] Seasonal

Allergies, Please List [ ] Antibiotics_____[ ] Medications_____

[ ] Food _____ [ ] Other_____

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING PROBLEMS:

[ ] No Medical Issues or History of Medical Issues

☐ ADD/ADHD	☐ Anemia/Blood Disorder	☐ Anxiety	☐ Arthritis
☐ Asthma/Hay Fever	☐ Autism/PDD	☐ Behavioral Disorder	☐ Bladder Condition
☐ Blood Transfusions	☐ Birth Defects	☐ Bone or Joint Problems	☐ Brain Injury
☐ Bruises Easily	☐ Cancer	☐ Cardiovascular Disease	☐ Cerebral Disorder
☐ Child Abuse	☐ Chronic Headaches	☐ Chronic Ear Infections	☐ Chronic Tonsil/Adenoid
☐ Cleft Lip/Palate	☐ Cold Sores/Blisters	☐ Congenital heart lesions	☐ Convulsions/ Seizures☐
☐ Diabetes	☐ Depression	☐ Down Syndrome	☐ Emotional Disturbance
☐ Epilepsy	☐ Excessive bleeding	☐ Excessive Gagging	☐ Fainting or Dizziness
☐ Growth & Development	☐ Hearing/Speech Problems	☐ Heart Disease/Condition	☐ Heart Murmur
☐ Hemophilia	☐ Hepatitis/Jaundice	☐ High Blood Pressure	☐ HIV/AIDS
☐ Immune Disorders(AIDS/HIV)	☐ Intellectual Disability	☐ Kidney Disease	☐ Leukemia
☐ Malignant Hyperthermia	☐ Neurological Problems	☐ Oral Ulcers (cankers)	☐ Orthopedic Problems
☐ Premature Birth	☐ Scoliosis	☐ Sensory Issues	☐ Spina Bifida
☐ Syndrome_____	☐ Thyroid Issues	☐ Tuberculosis	☐ Visual Impairment

☐ Other medical condition(s) we have not discussed that you feel we should be aware of? _____

_____

_____

RESPONSIBLE PARTY INFORMATION Who is responsible for the account? _____

Parents' Marital Status: □ Single □ Married □ Partnered □ Widowed □ Divorced □ Separated

□ **Mother** □ **Father** □ **Stepmother** □ **Stepfather** □ **Guardian** □ **Other**_____

RESPONSIBLE PARTY FULL NAME:_____**Date of Birth**_____

Address *if different* than patient_____

Home Phone_____ Cell Phone _____Work Phone: _____

Email _____ Social Security #_____

Employer_____ Occupation_____# Years Employed_____

If the above responsible party has Dental Insurance Coverage for the Child, please fill out below:

Insurance Company Name:_____ Insurance Phone #_____

Insurance Address:_____

Insurance Member ID# _____ Group #_____

□ **Mother** □ **Father** □ **Stepmother** □ **Stepfather** □ **Guardian** □ **Other**_____

RESPONSIBLE PARTY FULL NAME:_____**Date of Birth**_____

Address *if different* than patient_____

Home Phone_____ Cell Phone _____Work Phone: _____

Email _____ Social Security #_____

Employer_____ Occupation_____# Years Employed_____

If the above responsible party has Dental Insurance Coverage for the Child, please fill out below:

Insurance Company Name:_____ Insurance Phone #_____

Insurance Address:_____

Insurance Member ID# _____ Group #_____

Financial Information, Terms and Conditions

As a condition of treatment by this office, North Shore Pediatric and Orthodontics, PC, all fees for accounts must be paid at the time the service is performed. Accepted payment forms are Cash, MasterCard, Visa or Discover. The business staff must authorize any other payment arrangement in advance. Account balances over 30 days are subject to a finance charge of 1.5% month (18% per year) on the unpaid balance.

For patients who carry dental insurance, similar terms apply. This office will accept assignment of benefits, providing you pay all co-payments and deductible at the time the service is performed. Any insurance payment not received 45 days from the date of service will be charged to your account. We accept no responsibility in collecting overdue insurance claims or negotiating settlement of disputed claims.

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

_____ _____

Authorized Signature of Patient/Parent/Guardian Date

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Authorized Signature of Patient/Parent/Guardian Date