NORTH SHORE
PEDIATRIC DENTAL
& ORTHODONTICS

DR. LISA CAMPANELLA
900 CUMMINGS CENTER, STE 116-T
BEVERLY, MA 01915
PHONE: 978-236-1188
FAX: 978-236-1199

PATIENT INFORMATION

Date: _____

First Name _____ Last Name _____ Middle _____

Nickname: _____ Birth Date ____/____/____ Gender: _____

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 THE PATIENT HAS HAD ANY OF THE FOLLOWING:

[ ] No Medical Issues or History of Medical Issues

☐ ADD/ADHD	☐ Anemia/Blood Disorder	☐ Anxiety	☐ Arthritis
☐ Asthma/Hay Fever	☐ ASD (Spectrum Disorder)	☐ 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	☐ 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? _____

_____

_____

IF YOUR CHILD HAS ASD (AUTISM SPECTRUM DISORDER), PLEASE HELP US GIVE YOUR CHILD A POSITIVE EXPERIENCE BY ANSWERING THE FOLLOWING:

Does your child do the following? (Check all that apply)

- ☐ Communicate verbally?
- ☐ Communicate non-verbally?
- ☐ Make eye contact?
- ☐ Respond to verbal commands?
- ☐ Respond to verbal cues to establish communication?
- ☐ Respond to visual cues to establish communication?
- ☐ Respond to their name?
- ☐ Know how to count?
- ☐ Use repetitive words?
- ☐ Interact with others?
- ☐ Repeat what others say?
- ☐ Feel comfortable playing with others?
- ☐ Follow school rules/routines?
- ☐ Practice oral hygiene at home?
- ☐ Follow instructions on brushing?
- ☐ Feel comfortable sharing their personal space?
- ☐ Display unusual/intense reactions in medical settings?
- ☐ Display unusual/intense reactions to sudden noise, new odors or tastes?
- ☐ Display unusual/intense reactions to bright lights?
- ☐ Display unusual/intense reactions to sudden movements?
- ☐ Cope well with stressful situations?
- ☐ Follow specific words/phrases that help to cope in stressful situations?
- ☐ Undergo any behavior therapy such as ABA, OT, ST, or IEP?
- ☐ Have a very specific routine?
- ☐ Have specific flavors, food or beverages that they eat/drink or avoid?
- ☐ Need assistance with brushing?

How would you describe your child's mood today: _____

RESPONSIBLE PARTY INFORMATION Who is responsible for the account? _____

Parent/Guardian Relationship 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 North Shore Pediatric Dental and Orthodontics, all fees for accounts must be paid at the time the service is performed. For our self-pay patients, payment is expected at the time of service. Accepted payment forms are check, cash, MasterCard, Visa or Discover. If a check is returned for insufficient funds, we will assess a processing fee of $30.00 on your account and allow one week for receipt of payment. 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. If we refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. Allowing accounts to become perpetually overdue may result in dismissal from the Practice.

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. North Shore Pediatric Dental and Orthodontics cannot guarantee estimated coverage by your insurer, because that is an agreement between you and your insurance company. The criteria we use to establish our fees do not necessarily correspond with the criteria used by your insurer; for that reason you may be responsible for amounts not covered by your policy. Any insurance payments 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. Inaccurate information can cause delays in insurance reimbursements, you are responsible for providing updated insurance information. The Practice is not responsible for submitting past claims due to not being provided active insurance information.

Missed appointment or same day cancellation fees may be applied to your account if you cancel within 24 hours of your scheduled appointment, or do not arrive for your scheduled appointment. This fee must be paid before a new appointment is scheduled. Patients with several missed appointments may be dismissed from the Practice. Exceptions will be considered on an individual basis.

While we understand that a rare late arrival might be unavoidable, we may ask you to reschedule if you are late. While we will do our best to accommodate you, we may not be able to complete treatment in the shortened appointment time.

After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

I authorize North Shore Pediatric Dental and Orthodontics, PC to release to staff, hospitals, health care service plans, insurance companies, self-insurers or their representatives, any and all information, records, and radiographs about the patient's medical history, services rendered, or recommended treatment.

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.

My signature below indicates my acceptance of North Shore Pediatric Dental and Orthodontics' financial policies and terms and conditions.

_____ _____

Authorized Signature of Parent/Guardian Date

Privacy Practices

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of North Shore Pediatric Dental and Orthodontics Notice of Privacy Practices.

_____ _____

Authorized Signature of Parent/Guardian Date

Acknowledgement

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 Parent/Guardian Date