PDA DENTAL GROUP
PEDIATRIC | ORTHODONTIC | ADULT

955 Main Street, 101, Winchester, MA 01890 | 781-729-1900 | f:781-729-7102
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Pediatric Dentistry
Gary Warrington, DMD
Sonia J. Wu, DMD
Nicole J. Harrington, DMD
Matthew D. Freitas, DMD
Sean Ghassem-Zadeh, DMD
Patrick Cooper, DMD
Karina Vergara, DMD

Orthodontics
Shannon L. Duffy, DMD
Carolyn J. Ferrick, DMD

Adult Dentistry
Kimberly S. Weiss, DDS
Melissa Torres, DDS

PATIENT INFORMATION

_____ _____ _____ _____
Patient's Last Name | First Name | Home Telephone | Birthdate

_____ ____ _____ _____ _____
Nickname | Gender | Street Address | Town | Zip

_____ _____ _____ _____
Parent 1's Name | Birthdate | Social Security # | Occupation/Employer

_____ _____ _____ _____
Parent 2's Name | Birthdate | Social Security # | Occupation/Employer

Name and Age of Siblings:_____

PARENTS' INFORMATION: ❑ Single ❑ Separated ❑ Married ❑ Divorced ❑ Widowed

_____
Contact Email Address

_____ _____ _____ _____
Parent 1's Work # | Parent 1's Cell # | Parent 2's Work # | Parent 2's Cell #

_____ _____
Previous or Family Dentist | Telephone

_____ _____
Child's Physician | Telephone

Whom can we thank for referring you _____

FINANCIAL POLICY

Payment Is Due When Services Are Rendered. We accept cash, personal checks, MasterCard, Visa and Care Credit. In the case of divorce or separation, the parent bringing the child to the office will be deemed financially responsible.

APPOINTMENT POLICY

If you are unable to keep an appointment, we ask that you give our office at least 24 hours notice.
Missed appointment fees may be applicable.

INSURANCE INFORMATION

Your insurance policy is a contract between you, your employer and your insurance company. Therefore, you are responsible for understanding your coverage, benefits and yearly maximum. An authorization will be required to bill your dental insurance company. Please complete the following so that we will have this on file.

PRIMARY INSURANCE CARRIER

SUBSCRIBER_____
SUBSCRIBER ID#_____
SUBSCRIBER'S EMPLOYER_____
INSURANCE CARRIER_____
GROUP #_____
CLAIMS ADDRESS_____
CITY_____STATE_____ZIP_____

SECONDARY INSURANCE CARRIER

SUBSCRIBER_____
SUBSCRIBER ID#_____
SUBCRIBER'S EMPLOYER_____
INSURANCE CARRIER_____
GROUP #_____
CLAIMS ADDRESS_____
CITY_____STATE_____ZIP_____

I authorize my insurance company(s) to pay benefits directly to my dentist. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand that I am responsible for all copayments, deductibles and rejected charges.

I have read the above information and understand my obligations.

_____ _____
Signature of Policyholder | Date | Signature of Financially Responsible Party | Date

MEDICAL HISTORY

Patient Name:_____

1) Was your child premature? ❑ Yes ❑ No
2) Were there any difficulties during the pregnancy, delivery, or first year of life? ❑ Yes ❑ No
   a) Explain _____
3) Is a physician treating your child now for a specific illness? ❑ Yes ❑ No
   a) Explain _____
4) Is your child taking any medications at this time? ❑ Yes ❑ No

DRUG	DOSE	FREQUENCY	REASON

5) Has your child taken any medication in the past? ❑ Yes ❑ No
   a) Explain _____
6) Has your child had any allergies or unusual reactions to the following?
   a) Medications ❑ Yes ❑ No Foods ❑ Yes ❑ No Latex ❑ Yes ❑ No
   b) Other ❑ Yes ❑ No Explain _____
7) Has your child ever been hospitalized, had an operation or has an upcoming operation? ❑ Yes ❑ No
   a) Explain _____
   b) Was general anesthesia used? ❑ Yes ❑ No
      i) Any complications? ❑ Yes ❑ No
      ii) Explain _____
8) Are your child's immunizations up-to-date? ❑ Yes ❑ No

9) Has your child ever been diagnosed with any of the following conditions? Please check **yes or no**.

Y	N		Y	N		Y	N	
❑	❑	Acid Reflux/GERD	❑	❑	Chronic adenoid/tonsil	❑	❑	Heart murmur
❑	❑	ADD/ADHD	❑	❑	Chronic headaches	❑	❑	Hemophilia
❑	❑	Anemia/Bruising easily	❑	❑	Chronic ear infections	❑	❑	Hepatitis/Liver disease
❑	❑	Anxiety	❑	❑	Cleft lip/palate	❑	❑	HIV
❑	❑	Asthma	❑	❑	Congenital heart disease	❑	❑	Kidney disease
❑	❑	Autism	❑	❑	Convulsions/Seizures	❑	❑	Mental illness
❑	❑	Bacterial endocarditis	❑	❑	Depression	❑	❑	Nutritional deficiency
❑	❑	Bladder conditions	❑	❑	Diabetes	❑	❑	Oral ulcers
❑	❑	Blood transfusions	❑	❑	Down syndrome	❑	❑	Premature birth
❑	❑	Birth defects	❑	❑	Eating disorder	❑	❑	Rheumatic fever
❑	❑	Bone/Joint problems	❑	❑	Eye problems	❑	❑	Sickle cell anemia
❑	❑	Brain injury	❑	❑	Excessive gagging	❑	❑	Syndrome _____
❑	❑	Cancer/Malignancies	❑	❑	Fainting/Dizziness	❑	❑	Tuberculosis
❑	❑	Cerebral palsy	❑	❑	Growth/Dev. problems			
❑	❑	Child abuse	❑	❑	Hearing/Speech problems			

Other/Additional comments:

_____

_____

_____

DENTAL HISTORY

1) Please check reason(s) for seeking dental care
   - ❑ First Examination ❑ Routine Check-up ❑ Toothache or swelling
   - ❑ Appearance of teeth ❑ Crowding of teeth ❑ Accident
   - Other_____
2) Has your child been to a dentist previously? ❑ Yes ❑ No
   a) When was the last visit? _____
   b) Have x-rays been taken? ❑ Yes ❑ No When? _____
   c) How would you describe your child's temperament?
      - ❑ Outgoing ❑ Shy ❑ Stubborn ❑ Anxious ❑ Frightened ❑ Regular Kid
      - ❑ Curious ❑ Moody ❑ Friendly ❑ Defiant ❑ High Strung ❑ Cooperative
3) How do you think your child will react to dental treatment? _____

4) Does your child have fluoride in any of the following forms?
   a) Toothpaste ❑ Yes ❑ No Brand _____
   b) Drinking Water ❑ Yes ❑ No
   c) Topical Application ❑ Yes ❑ No
   d) Fluoride Tablets ❑ Yes ❑ No **(0.25 mg / 0.5 mg / 1.0 mg)**

5) Does your child brush his / her **own** teeth? ❑ Yes ❑ No
   a) When? ❑ AM ❑ PM ❑ After Snacks ❑ Before Bed ❑ After Breakfast
6) Do **you** brush your child's teeth? ❑ Yes ❑ No
   a) When? ❑ AM ❑ PM ❑ After Snacks ❑ Before Bed ❑ After Breakfast
7) Do **you** or **your** child use dental floss in cleaning your child's teeth? ❑ Yes ❑ No
   a) When? ❑ AM ❑ PM ❑ After Snacks ❑ Before Bed ❑ After Breakfast

8) Does your child have snacks in between meals? ❑ Yes ❑ No

9) Have your child's teeth ever been injured? ❑ Yes ❑ No

10) Does your child have any of the following habits?
   - ❑ Thumb or finger sucking ❑ Lip sucking or biting ❑ Bottle to bed at night
   - ❑ Pacifier ❑ Mouth Breathing

I hereby give permission to Pediatric Dental Associates to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, topical and local anesthetic (injections), radiographs, etc.

Patient Name:_____

Signature of legal guardian _____ Date _____