Belmont Pediatric Dentistry
Dr. Jolle Hami
11 Alexander Avenue
Belmont, MA 02478
617-484-3838

Today's Date:

Patient Information

Patient's Name_____Sex_____Birthdate_____

Patient's address_____

Phone # (Home)_____ (Cell)_____ Email Address_____

1st Parent's Name_____ Address (if different) _____

Phone # (Home)_____ (Cell)_____ (Work)_____

Email Address_____ Occupation_____

2nd Parent's Name_____ Address (if different) _____

Phone # (Home)_____ (Cell)_____ (Work)_____

Email Address_____ Occupation_____

With Whom Does the Patient Live? _____ Who referred you to us? _____

Previous dentist (name and address) _____

Date of last dental appointment_____

Responsible Party Information

Name_____ Relationship to patient_____

Address (if different) _____Phone#_____

Social Security#_____ Birthdate_____ Employer_____

Primary Dental Insurance Information

Insured's Name_____ Birthdate_____

Subscriber ID #_____ Group#_____

Insurance Company _____Ins. Co. Address_____

Ins. Co. phone#_____ Insured's Employer_____

Secondary Dental Insurance Information

Insured's Name_____ Birthdate_____

Subscriber ID #_____ Group#_____

Insurance Company _____Ins. Co. Address_____

Ins. Co. phone#_____ Insured's Employer_____

It is important that I know about your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone.
Thank you for taking the time to completely fill out this questionnaire.

(Page 2) Patient's Name: _____

HEALTH

Physician's name _____ Phone # _____

Is your child under the care of, or being treated by a physician now? ____ If so, for what reason? _____

Does your child have regular medical check-ups? _____How often? _____

Is your child taking any medications? _____If so, what? _____

Is your child allergic to anything that you know of? _____foods? _____Medications? _____

Does your child bruise easily? _____Have frequent nosebleeds? _____

Has your child ever bled excessively after a cut or injury? _____

Has a dentist or physician warned you about giving your child any specific drug or medication? _____
If so, what?_____

Has your child ever been given local anesthesia (Novocain)?_____Were there any unfavorable reactions to this?_____

Has your child ever been in a hospital overnight? _____Why? _____
Were there any complications? _____
How well does your child accept his/her physician? _____

Please check what illnesses your child had:

_____Rheumatic Fever	_____Kidney Disease	_____Mumps
_____Heart Disease	_____Heart Murmur	_____Measles
_____Asthma	_____Diabetes	_____Chicken Pox
_____Lung/Respiratory Disease	_____Nervous/Emotional Disorder	_____Liver Disease
_____Seizure Disorder		

DENTAL

Is this your child's first visit to a dentist?_____If not, when was your child examined, and how well did he/she accept treatment?_____

Have dental x-rays been taken of your child? _____If yes, when? _____

How often are your child's teeth brushed? _____Are they brushed after meals? _____

Has your child had fluoride of any kind (supplements, vitamins, in the water)? _____
Has your child had fluoride applications to his/her teeth? _____If so, when? _____
Does your child use a toothpaste that contains fluoride? _____

When did your child completely give up the bottle? _____

Does your child have any of the following habits?

_____Breathes through mouth	_____Sucks thumb or fingers
_____Tongue habit	_____Bites or sucks lips
_____Bites fingernails	_____other_____

Please write any additional remarks that may be helpful in rendering care to your child_____
_____

****The signature of a parent of guardian affixed below authorizes the completion of all agreed upon necessary dental services.**

Signature_____**Date**_____

Relationship to Child_____