Cheshire Dental Associates

0 – 18 year old patients

Patient Name _____ Date of Birth _____

Patient Social Security # _____ Referred By _____

Parent/Guardian Name _____ Parent/Guardian DL # & State _____

Address _____

City, State, Zip _____

Cell Phone _____ Home Phone _____

Other Phone _____ Email _____

Preferred pharmacy & location _____

How should we contact you? Cell Phone_____ Home Phone_____ Other Phone_____ Email _____

Cheshire Dental Associate bills may be sent electronically via ___ text/email or ___ paper statement via mail. Please indicate preferred method.

Cheshire Dental Associate appointments may be confirmed electronically via text/email through our system. You may opt out of our electronic confirmation system and you will receive phone calls to confirm at the number given. Thank you.

Your Primary Insurance Company Name		Effective Date
Primary Insurance Company's Address		Phone
City	State	Zip
Name of Insured		Date of Birth
Policy Holder's ID number		Group Plan Number
Employer's Name		
Your Secondary Insurance Company's Name		Effective Date
Primary Insurance Company's Address		Phone
City	State	Zip
Policy Holder's ID Number		Group Plan Number
Employer's Name		

1. Payment is expected at the time the work is done. Although you may have insurance, your "Patient Portion" must be paid at the time of visit.
2. Financial agreements must be made if payment in full at each visit is not possible. Finance charge of 1.5% (18% annually) will be added monthly after 60 days to any unpaid balance. In the event of default, the patient and/or parent/guardian are liable for all collection costs and reasonable attorney fees.
3. We accept Cash, Check, Credit Cards, Care Credit.

Signature of Parent/Guardian _____ Date _____

Dental and Oral Health Information

Patient Name _____ Today's Date _____

Please describe any specific dental problem or discomfort your child is having at this time _____
_____ How long has it been present? _____

If your child has had any of the following dental care please list the dentists and approximate dates
Periodontal (gum) treatment or surgery _____
"Braces" or any type of orthodontic treatment _____
Any other type of oral surgery _____

How do you rate your child's overall dental health? □ Good □ Fair □ Poor
How many times a day do you/your child Brush their teeth? _____ Floss their teeth? _____

Does your child use any of the following? (Please check Yes or No for each question)	Yes	No
Mechanical (electric toothbrush) If yes, what type or brand? _____	____	____
Flossing aids (threaders, floss holders, etc.)	____	____
Oral irrigating device (waterpik)	____	____
Mouthwashes or oral rinses. If yes, what type or brand? _____	____	____
Fluoride treatments or supplements at home. If yes, which ones: _____	____	____

Type of water at home? □ City □ Well
Is child currently using fluoride toothpaste? □ Yes, using _____ □ No, using _____

Any injuries to mouth, teeth, head? □ Yes, _____ □ No
Any unhappy dental experiences? □ Yes, _____ □ No

Does your child have any mouth habits? □ Yes (Please select all that apply below) □ No
□ Pacifier □ Thumb sucking □ Sleeping with bottle □ Nail biting □ Mouth breathing/Snoring

Has your child ever had treatment completed with nitrous oxide (laughing gas)? □ Yes □ No
Any adverse reactions to nitrous oxide (laughing gas)? □ Yes,_____ □ No

If your child is a new patient to this practice

Date of last dental visit _____ For what service(s)? _____

Dentist's name _____ City & State _____

Reviewed by _____

Health Information and History

Today's Date _____

Patient Name _____ Date of Birth _____

If you are completing this form for another person:
Your Name _____ Phone _____ Relationship _____

Emergency contact (if not listed above):
Your Name _____ Phone _____ Relationship _____

Primary Physician _____ Phone _____ City & State _____

Date of last physical exam _____ Height _____ Weight _____ Date of last blood workup _____

1. Within the last 3 years has your child been hospitalized or had surgery? □ Yes □ No
   If yes, please give reasons & dates: _____

2. Has your child ever been instructed to take ANY medications or special precautions before dental appointments?
   □ Yes □ No
   If yes, please explain reasoning & medication _____

3. Is your child taking any drugs, medications, or treatments at this time? □ Yes □ No
   If yes, please list any prescribed, over the counter (OTC), and/or vitamins/supplements your child takes:
   _____
   _____

4. Is your child having or ever had radiation or chemotherapy treatments? □ Yes □ No
   If yes, why? _____ When? _____
   For how long? _____ Facility performing treatment? _____

5. Is your child allergic to or ever experienced an unusual reaction of the following: (Please write yes or no for each)

__ Penicillin/Amoxicillin	__ Aspirin/Ibuprofen	__ Acetaminophen	__ Codeine	__ Iodine
__ Red Dye	__ Peanuts	__ Tree nuts	__ Latex	__ Fluoride
__ Metals/jewelry	__ Dental Anesthesia (Local)	__ General Anesthesia	__ Nitrous Oxide (Laughing gas)	

6. Has your child had an allergic reaction or unusual response to ANY other medications, treatments, or anything not listed above that you'd like us to know about? □ Yes □ No
   If yes, please list: _____

Reviewed by: _____

7. Does your child have any history of, difficult with, or diagnosis of any of the following?
(Please check Yes or No for each question)

	Yes	No
Anemia	___	___
Arthritis	___	___
Artificial Heart Valve	___	___
Repaired or unrepaired (please circle)		
Asthma	___	___
Autoimmune Disorder	___	___
Type _____		
Bladder problems	___	___
Bleeding disorders	___	___
Eye problems	___	___
Type _____		
Excessive bleeding when cut	___	___
Bones/joints	___	___
Cancer	___	___
Type _____		
Cerebral Palsy	___	___
Chicken pox	___	___
Compromised immune system	___	___
Congenital heart defect	___	___
Diabetes/Blood sugar problems	___	___
Epilepsy or other seizure disorders	___	___
Fainting	___	___
Growing Problems	___	___
Hearing problems	___	___
Heart problems	___	___
Heart surgery	___	___
Hepatitis	___	___
HIV/AIDs	___	___
Kidney disease	___	___
Liver disease	___	___
Measles	___	___
Mental health issues	___	___
Mononucleosis	___	___
Mumps	___	___
Organ transplant	___	___
Type _____		
Rheumatic fever	___	___
Seasonal allergies	___	___
Sinus problems	___	___
Sickle cell	___	___
Stomach problems	___	___
Thyroid problems	___	___
Tobacco/Drug use	___	___
Tuberculosis	___	___

If you answered yes to any of the above conditions, please explain: _____
_____
_____

8. Does your child have any other conditions, diseases, or medical problems, or is there ANY other information that you would like us to know, or that we should be made aware of? □ Yes □ No
If yes, please explain: _____
_____
_____

Signature _____ Date _____
(Patient or parent/guardian if patient is a minor)

Reviewed by: _____

Cheshire Dental Associates, P.C.

CONSENT

To the best of my knowledge, all of the given information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient's health information released to aid in care treatment. I also hereby consent to allow diagnosis, proper healthcare and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

Signature _____ Date _____
(Patient or parent/guardian if patient is a minor)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

Signature _____ Date _____
(Patient or parent/guardian if patient is a minor)

Print Name _____

MISSED APPOINTMENTS & LATE ARRIVAL POLICIES

Cheshire Dental Associates strives to appoint our patients in such a manner as to maximize our service potential. We also allow time to ensure your dental needs are met with as minor an impact on your busy schedule as possible.
It is appropriate if you need to cancel an appointment to give us a 24-hour notice as we may contact a patient who is on our waiting list to better serve their needs.

For any missed appointment that was not cancelled with CDA personnel at least 24 hours in advance, a $25.00 fee will be charged to your account. Subsequent missed appointments will be subject to additional fees.
If you are going to be more than 5 minutes late to your appointment, please call our office to update staff on your arrival time. Cheshire Dental Associates has the right to reschedule any appointment due to excessive tardiness.

Signature _____ Date _____

Reviewed by _____