LEXINGTON
PEDIATRIC DENTAL

Dear Parent:

Thank you for choosing our practice for your child's first dental experience. It is our goal to make this big moment as enjoyable as possible for your child. With this in mind, I would like to give you some hints on preparing your child for their first appointment.

The initial visit is extremely important since this first impression of the dental experience has lifelong implications. Fear is a learned response and the way your child reacts to the dental appointment can be greatly influenced by how you prepare your child at home. Children are very intelligent and observant and can sense parental emotion in many ways. Many adults have a strong dislike or fear of dentistry. Since the environment in our practice is geared towards children of all ages, there is nothing to fear.

Usually the first visit consists of parent education and the child having his/her teeth counted (examined). This insures that the child has a fun and easy experience, finishing with the receipt of a new toothbrush, stickers, and prizes.

On the second visit we introduce the electric toothbrush (polisher), floss, and vitamins (topical fluoride treatment). As far as pictures (radiographs) are concerned, we generally decide together when they are required. All your child needs to know for the first visit is that he/she is going to have his/her teeth counted and receive a new toothbrush and surprises. Please do not make any references to more complicated aspects of dentistry that you have experienced, and refrain from offering rewards or bribes for good behavior. The office is geared towards making your child comfortable and knowledgeable about good oral hygiene.

If you have any questions, feel free to call.

Sincerely yours,

Ronit Antebi-Hadar, DMD

Lexington Pediatric Dental
3 Bow Street, Lexington, MA 02420
T 781. 861.8800 F 781.860.7710
www.lexingtonpediatricdental.com

DENTAL REGISTRATION AND HEALTH HISTORY

Patient Name_____ How do you prefer to be addressed?_____

Mailing Address_____ City_____ State_____ Zip_____

Sex: ☐ M ☐ F Age_____ DOB_____ Home Phone#_____

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

Do you have Dental Insurance? ☐ Yes ☐ No If *yes*, please fill out the **Insurance Information** section.

If the person responsible for this patients account is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section titled "Insurance Information"

Name of Responsible Party_____ Relationship to Patient_____ Sex: ☐ M ☐ F

Mailing Address_____ City_____ State_____ Zip_____

Age_____ DOB_____ ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Separated ☐ Divorced

Home Phone#_____ Work Phone# _____ Cell Phone#_____

E-Mail
Address_____

Occupation_____ Employer_____

Employer Address_____ City_____ State_____ Zip_____

Where would you like us to confirm appointments? Please check ***one*** of the following: ☐ Home ☐ Work ☐ Cell ☐ E-mail ☐ Text

INSURANCE INFORMATION

Policy Holders Name_____ Relationship to Patient_____

DOB_____ Subscriber ID# or Social Security#_____

Name of Employer_____ Employer Address_____

Insurance Company_____ Group#_____

Insurance Address_____ City_____ State_____ Zip_____

Answers to the following question are for our records only and will be considered confidential

1. Have you or any member of your family been seen by us before? ☐Yes ☐ No
   If yes, which family member(s)?_____
2. Date of last physical examination_____ Physician's Name & Phone#_____
3. Date of last dental examination _____ Date of last dental x-rays_____
4. Previous Dentist's name_____ City/State_____
5. Are you having discomfort at this time? ☐ Yes ☐ No
6. Do you feel nervous about having dental treatment? ☐ Yes ☐ No
7. Have you ever had a bad experience in a dental office? ☐ Yes ☐ No
8. Is there anything you dislike about your smile? ☐ Yes ☐ No
9. Is there anything you would like to speak with the Doctor about in private? ☐ Yes ☐ No
10. Have you been a patient in the hospital during the past two years? ☐ Yes ☐ No
11. Have you been under the care of a medical doctor during the past two years? ☐ Yes ☐ No
12. Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No
13. Are you taking any vitamins, herbal supplements or "cures"? ☐ Yes ☐ No
14. Have you ever had any excessive bleeding requiring special treatment? ☐ Yes ☐ No
15. Emergency Contact Name & Phone#_____

Please check any of the following that apply:

ALLERGIES

□ Aspirin
□ Codeine
□ Iodine
□ Latex
□ Food:_____
□ Local Anesthetic
□ Penicillin
□ Sulfa
□ Metals
□ Other:_____

MEDICATIONS

Please list any medications you are currently taking:

_____
_____
_____

Pharmacy:_____

□ ADD or ADHD	□ Heart Murmur
□ Anemia	□ Heart Problems
□ Any Type of Transplant	□ Hepatitis A, B, C or Other
□ Asthma	□ HIV Positive, ARC, AIDS
□ Blood Disease	□ Hives or Skin Rash
□ Blood Transfusion	□ Jaundice
□ Bruise Easily	□ Mental Disability
□ Cold Sores	□ Persistent Cough
□ Diabetes	□ Psychiatric Treatment
□ Eating Disorder	□ Recent Surgery/Hospitalization
□ Epilepsy or Seizures	□ Shortness of Breath
□ Fainting of Dizzy Spells	□ Sinus Trouble
□ Genetic Conditions _____	□ Syndromes _____
□ Hay Fever	□ Tuburculosis (TB)

Have you ever experienced any of the following problems with your jaw?
□ Clicking □ Difficulty Chewing □ Difficulty opening or closing □ Pain in or around your ears
Do you currently or have you ever had any problems listed below?
□ Swelling □ Bad Taste □ Bleeding Gums □ Loose Teeth
Are you sensitive to anything listed below?
□ Hot □ Cold □ Biting/Pressure □ Sweets □ Other_____

Do you have a history of trauma to your jaw? □ Yes □ No
Have you ever been diagnosed with TMJ/TMD? □ Yes □ No
Do you have any sores/lumps/growths in/near your mouth? □ Yes □ No
Have you ever had difficult extractions in the past? □ Yes □ No
Have you ever had prolonged bleeding following extractions? □ Yes □ No
Do you habitually clench or grind your teeth day or night? □ Yes □ No
Do you have a problem with bad breath (Halitosis)? □ Yes □ No
What is your chief dental complaint?_____
_____
_____

Do you have any trouble chewing? □ Yes □ No
Does food collect between your teeth? □ Yes □ No
Have you had instructions in oral hygiene? □ Yes □ No
Please circle any of the following habits:
Tongue thrust/Digit sucking/Nail biting/Other _____
Is there anything related to your medical or dental history that has not been indicated above? □ Yes □ No
If yes, please explain_____
_____
_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or guardian **Date**

Payment Policy

Thank you for choosing Lexington Pediatric Dental as your dental health care provider. We are committed to the success of your dental treatment and want to provide you with the best service available. To help reduce our administrative costs and keep our fees to you as low as possible, we require payments to be made at or prior to the time that you (or your family members) receive treatment. Please indicate below the method of payment you intend to use.

My preferred payment option is:

___ Cash
___ Check
___ Major credit card (Visa, MasterCard, or American Express)

*** For treatment amounts over $300, please inquire about the possibility of an extended payment plan.

A note for patients with dental insurance

Dental insurance usually does not cover the total cost of your treatment. Based on your plan, we usually can estimate the amount of your co-payment. When treatment is delivered to you, your co-payment will be expected at that time. If your insurance company fails to pay within 60 days after we submit your claim, you will be responsible for the full fee.

Acceptance Agreement

I understand and agree with the above financial policy. I understand the parent or relative bringing a child for dental treatment is responsible for all fees incurred at that visit. I further understand that I am responsible for ALL fees, regardless of insurance coverage.

Patient (Print Name) _____

Parent or Guardian (Print Name) _____

Parent or Guardian (Signature) _____ (Date)_____

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Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment

I, _____, have received a copy of this
Print Name

office's Notice of Privacy Practices.

_____
Print Patient Name

_____
Signature of Parent or Guardian

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of Notice of Privacy Practices, but acknowledgment could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

_____

_____

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