

PEDIATRIC DENTISTRY AT LONGWOOD, PC

Dr. Jeffrey Melini
400 McFarlan Road, Suite 200
Kennett Square, PA 19348

610-925-5700

Date: _____

Patient Information

Name: _____ Sex M F Birthdate: _____
Address: _____ City, State, Zip _____
Telephone: H) _____ W) _____ Cell) _____ email _____
Full Time Student: School Name _____ State: _____ Yr. of Grad. _____

Parent Information

Mother's Name: _____ Address: _____
Home: _____ Work: _____ Cell: _____ Email: _____
Father's Name: _____ Address: _____
Home: _____ Work: _____ Cell: _____ Email: _____
Person Responsible for Account: _____ Relationship to Patient: _____
Whom May We Thank For Referring You: _____

In Case of Emergency, Please Contact: (please specify someone not in your household)

Name: _____ Relationship: _____
Telephone: H) _____ W) _____

Insurance Information

Primary Insured	Secondary Insured
Subscriber: _____	Subscriber: _____
Address: _____	Address: _____
Telephone: _____	Telephone: _____
Birthdate: _____ Relationship to patient: _____	Birthdate: _____ Relationship to Patient: _____
SSN: _____ Subscriber ID: _____	SSN: _____ Subscriber ID: _____
Employer: _____ Group # _____	Employer: _____ Group# : _____
Dental Ins. Co: _____	Dental Ins. Co: _____

Authorization

We will reserve a space for you and /or your family member(s) in our schedule. Please advise our office within 48 hours if for whatever reasons you and/or your family members will not be able to keep the appointment. If we are not contacted within 48 hours prior to the appointment, you will be responsible for a \$25.00 fee for each appointment that was scheduled. If three appointments are missed by you and/or your family member(s) that was not properly notified, you will be dismissed as a patient.

*I understand that my dental insurance is a contract between the insurance carrier and me and as such, agree that regardless of the insurance company's coverage, I am responsible for all fees incurred as a result of treatment received at Pediatric Dentistry at Longwood, PC. I hereby authorize payment directly to **Pediatric Dentistry at Longwood, PC** of the group dental benefits, otherwise payable to me. My payment (or co-payment, if there is dental insurance) is due at the time of treatment.*

*I hereby authorize **Pediatric Dentistry at Longwood, PC.** to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge.*

I grant consent to the dentist to the use and disclosure of protected health information to carry out treatment, payment activities, and healthcare operations. I further grant release of my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals, whether manually or electronically. A copy of the Notice of Privacy Practices has been provided to me, upon request.

As guarantor of my account, I understand that I am financially responsible for all of the fees for the dental treatment. I further agree that I have received a copy of the office financial policy and agree to its contents.

Signature _____ Date _____

Patient Name: _____ Date: _____

DENTAL HISTORY

please circle

Why did you bring the child to the dentist today? Describe _____
Has the child ever had a serious/difficult problem associated with previous dental work? _____ Yes No
Is the child's water fluoridated? _____ Yes No
Is the child taking fluoridated supplements? _____ Yes No
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? _____ Yes No
Does the child brush his/ her teeth daily? _____ Yes No
Floss his/ her teeth daily? _____ Yes No
Name of previous dentist? _____
Date of last x-rays (16 small films or panoramic) _____ Yes No

MEDICAL HISTORY

Child's Physician: _____ Phone _____ Date of Last Visit _____
Is the child under a physician's care now? Why? _____ Yes No
Please describe the child's current physical health: Good Fair Poor _____
Has the child ever taken Fosamax, Actonel, Boniva or any other biphosphonate? _____ Yes No
Have you ever been hospitalized or had a major operation? Discuss _____ Yes No
Are your child's immunizations current? _____ Yes No
Have you seen an ENT (ears, nose, throat) doctor? Name _____ Yes No
Is your child allergic to any medications or substances? Discuss _____

Please check any of the conditions that apply:

- | | | |
|--|---|---|
| <input type="checkbox"/> AIDS/HIV+ | <input type="checkbox"/> Exposed to HIV, but neg. | <input type="checkbox"/> Measles |
| <input type="checkbox"/> ADD /ADHD | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Handicaps/Disabilities | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Any Hospital Stays | <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Neurological Disorders |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Radiation Treatment/Chemotherapy |
| <input type="checkbox"/> Artificial Bones/Joints | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell Disease/Trait |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Hives | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Skin Rash |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Low Blood Pressure | |

Do you have or have you had any disease, condition or problem not listed?

Please List all medications (prescribed or OTC), supplements, and herbs that your child is taking:

HABITS

Does/did the child experience any of the following?

Lip sucking/biting Pacifier Habits Nail Biting Thumb/Finger Sucking
Was the child breast fed? Yes No

ALLERGIES

Please check if you are allergic to any of the following, including flavorings and food coloring?

Aspirin Barbituates Iodine Local Anesthetic Penicillin
 Augmentin Codeine Latex Metals Sulfa
 Others _____

The above information is accurate and complete to the best of my knowledge. I will not hold the dentist or any member of the team responsible for errors or omissions that I may have made in the completion of this form.

Signature of Patient, Parent/Guardian if minor _____

Date _____