Cara Donley Pediatric Dentistry
Patient Registration and Health History

1. **Child's Name** ________________________ Middle Initial:____ Nickname_________________
   Child's Address:____
   Street *City, State* *Zip*
2. Sex: Male □ Female □ Birth date: _________Age: _____ Home Phone: ___________________
3. Hobbies or Interests:____
4. Siblings:*(ages)*____
5. Is this your child's first visit to the dentist? ____
6. Does your child have any habits, which might affect the mouth or teeth?
   Breathes through mouth ____________________Sucks thumb or finger__________________
   Pacifier________________________Nail biting ____________________________________
7. Has your child ever experienced trauma to the mouth or teeth? ___________________________
   If yes, describe____
8. Does your child use a bottle or a sippy cup?____
9. Do you have any dental concerns for your child? _____________________________________
   If yes, describe____
10. Has your child had dental x-rays taken? _____ Date taken_____________________________

11. **Mother's Name** ***(or responsible party)***________________________Birth date: ____________
12. Drivers License:________________ Soc. Sec.____
13. Address:____
    Street *City, State* *Zip*
14. Employer:____________________________ Business Phone:___________________________
15. Employment Address: ____
16. Cell Phone:__________________ E-mail Address:____________________________________

17. **Father's Name** ***(or responsible party)***________________________Birth date: ____________
18. Drivers License:__________________ Soc. Sec.______________________________________
19. Address:____
    Street *City, State* *Zip*
20. Employer:____________________________ Business Phone:___________________________
21. Employment Address: ____
    Street *City, State* *Zip*
22. Cell Phone:_____________________ E-mail Address:_________________________________

Primary Dental Insurance Information

1. Name of Insured:____
2. Relationship to Patient: Self □ Mother □ Father □ Other □ __________________________
3. Insured Social Security:________________________ Insured Birth date:___________________
4. Insurance Provider:___________________________ Group #:____________________________
5. Subscriber Number: ____

Emergency Information

In case of an emergency, Please contact:______________________ Phone:___________________
How did you hear about our office:_______________________________ Relationship:__________

Medical History

1. Is your child in good health? Yes □ No □
2. Child's Pediatrician:_______________________________ Phone:__________________________
3. Pediatrician's Address:____
4. Date of last physical exam:____
5. Were there any difficulties during the pregnancy? (e.g. prematurity)
   or during your child's first year of life? Yes □ No □
   If yes, describe____
6. Is your child under care of a physician now for any reason? Yes □ No □
   If yes, describe:____
7. Is your child currently taking any medications? Yes □ No □
   Drug:___________________________ Reason:____
8. Has your child had any allergic reactions (including hives) to any of the following?
   Aspirin□ Amoxicillin/ Penicillin□ Codeine□ Acrylic□ Metal□ Latex□ Local Anesthetics□
   Other□ If Yes, explain:____
9. Allergic reaction to any foods? Yes □ No □
   If yes, describe____
10. Has your child ever been hospitalized? Yes □ No □
    If yes, describe____
11. Has your child had any surgeries (operation)? Yes □ No □
    If yes, please describe when, where and reason:____
    Were there any complications? Yes □ No □
    If yes, describe____
12. Has your child ever had problems with pain, bleeding, or healing? Yes □ No □
13. Are your child's immunizations current? Yes □ No □

Please check all that apply.

□ Abuse (physical or sexual)	□ Diabetes	□ Orthopedic Problems
□ Anaphylaxis	□ Emotional Disability	□ Psychiatric Care
□ Anemia	□ Epilepsy or seizures	□ Rheumatic Fever
□ Arthritis	□ Fainting (often)	□ Sickle Cell Trait
□ Asthma	□ Gastrointestinal Disorders	□ Snoring
□ Autism	□ Hearing Loss Type:____	□ Speech problem
□ Bleeding (prolonged)	□ Heart Disease/Murmur	□ Spina Bifida
□ Blood Transfusion	□ Hepatitis Type:_____	□ Stomach/Intestinal
□ Brain Injury	□ HIV infection AIDS	□ Tonsillitis
□ Bruise Easily	□ Learning Disability	□ Tuberculosis
□ Cancer: Type:__________	□ Kidney Disease	□ Thyroid
□ Cerebral Palsy	□ Leukemia Type:______	
□ Cleft Lip/Palate Type:_______	□ Developmental Delay	

Have you ever had any serious illnesses not listed above? Yes □ No □
If yes, briefly explain: ____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE of Parent or Guardian_______________________________**DATE**__________________

Acknowledgement of Receipt of Notice of Privacy Practices

Cara L Donley DMD Pc
327B Boston Post Road
Sudbury, MA 01776

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

Print Name:____

Signature:____

Date:____

* You May Refuse to Sign This Acknowledgment*

For Office Use Only

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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Informed Consent for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.
It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.
Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided. I understand that during my course of treatment that the following care may be provided:
Examinations_____ Preventive Services_____
Restorative treatment (fillings)_____ Extractions_____

Patient Initials_______

2. Drugs and Medications. I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

Patient Initials_______

3. Changes in Treatment Plan
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary.

Patient Initials_______

4. I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Patient Initials_______

_____________________________________ __________________
Patient Signature Date