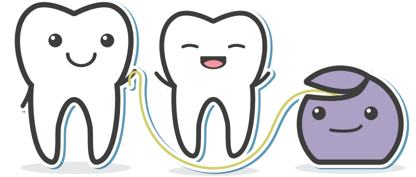
HASSEY | DO DUY
DENTAL ASSOCIATES

100 Milk Street, Suite 120
Methuen, MA 01844

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.



PATIENT INFORMATION

Today's Date

Name of Minor / Child	Birth Date	Social Security Number

Nickname	Hobbies	Gender ☐Male ☐Female Age ____________

Home Address	City	State	Zip Code
Mailing Address	City	State	Zip Code

Cell Phone	School Name	School Phone
Name of Person Financially Responsible for this Account	Relationship to Patient	Cell Phone

Whom may we thank for referring you?

DENTAL INSURANCE INFORMATION

Father / Guardian's Name	Birth Date	Social Security Number

Address (If different from the patient)	City	State	Zip Code

Cell Phone	Work Phone	Do you have dental insurance for the minor / child? ☐ Yes ☐ No
Email Address	Employer	
Insurance Company	Group Number	Policy Number

Insurance Company Address	City	State	Zip Code

Mother / Guardian's Name	Birth Date	Social Security Number

Address (If different from the patient)	City	State	Zip Code

Cell Phone	Work Phone	Do you have dental insurance for the minor / child? ☐ Yes ☐ No
Email Address	Employer	
Insurance Company	Group Number	Policy Number

Insurance Company Address	City	State	Zip Code

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No	Child Medical Assistance I.D. Number

DENTAL HISTORY

Reason for today's visit	Date of Last Dental Exam
Previous Dentist / Location	Date of Last Dental X-rays

Has child complained about dental problems? ☐ Yes ☐ No
Does child brush teeth daily? ☐ Yes ☐ No
Does child use floss daily? ☐ Yes ☐ No
Is fluoride taken in any form? ☐ Yes ☐ No

Any injuries to mouth, teeth, head? ☐ Yes ☐ No
Any unhappy dental experiences? ☐ Yes ☐ No
Any mouth habits - thumb-sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐ Yes ☐ No

OVER PLEASE

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MEDICAL HISTORY

Minor / Child's Physician's Name	Date of Last Visit

City / State	Physician's Phone Number

Is Minor / Child under care of physician now? ☐ Yes ☐ No If yes, please explain? ______

Receiving any medication or drugs? ☐ Yes ☐ No If yes, please explain?______

Ever been hospitalized? ☐ Yes ☐ No If yes, please explain? ______

Ever had surgery? ☐ Yes ☐ No If yes, please explain? ______

Is there excessive bleeding when cut? ☐ Yes ☐ No If yes, please explain? ______

Does the minor / child have any allergies? ☐ Yes ☐ No If yes, please explain? ______

Has minor / child had any history of or difficulty with any of the following? If yes, please indicate.

☐ AIDS/HIV Positive	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rhuematic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other ______

EMERGENCY CONTACT

Name	Relationship	Phone Number
Name	Relationship	Phone Number

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if my minor child ever has a change in health.

Minor / Child Consent

I am the parent, guardian, or personal representative of ______ (Please Print Name of Minor / Child) and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to preform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with ______ (Name of Insurance Company(ies) and assign directly to Dr. ______ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______ Signature of Patient, Parent, Guardian or Personal Representative

______ Please print name of Patient, Parent, Guardian or Personal Representative

______ Relationship to Patient

______ Date

UPDATES (To be filled in at future appointments)

Has there been any changes in the patients health since their last dental appointment? ☐ Yes ☐ No
If yes, please explain? ______

Is the patient taking any new medications? ☐ Yes ☐ No If yes, please explain? ______

Parent / Guardian Signature ______ Date ______

Doctors Signature ______ Date ______

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Communication is important to us as a part of your complete dental care.
Please take a moment of your time to review our policies.

FIRST APPOINTMENT

Your first appointment will consist of a full mouth series of x-rays and a full oral exam. If you have any recent x-rays taken from a previous dentist, please try to obtain a copy and bring them with you on your first appointment.

MEDICAL HISTORY

We will ask that you review your medical history at each recall visit with your hygienist. Many changes occur in your health that we need to be aware of.

RECALL APPOINTMENTS

You are encouraged to schedule your recall appointment in advance. We will send a reminder postcard 2 weeks in advance of these visits. A reminder will also be sent if you choose not to schedule your appointment in advance.

CANCELED/FAILED APPOINTMENT

Notifying us 48 hours in advance of your appointment will help us to avoid scheduling problems.

PAYMENTS

Payment is expected at the time of each visit. We will advise you of your treatment needs and estimated expense. Should your treatment be extensive, we can arrange for a plan to pay. We accept Master Card, Visa, Discover, and American Express. We also offer a payment plan called CareCredit that allows treatment to start today and spreads payments over time. These arrangements will be discussed individually.

Your account must remain in good standing prior to your next visit.

INSURANCE

Our front desk staff will provide the courtesy of submitting your dental claims, including a reasonable follow-up of unpaid claims. You will be expected to provide a percentage of your fee at each visit. Our new computer system allows us to continually update your specific insurance policy. You will see that our billing system will become more accurate to your "estimated portion due." Until specific information is collected, your payment will be based on the insurance standard of: 100% Hygiene visits, 80% Restorative visits, 50% Major restorative visits.

Please note that generally insurance benefits for posterior white fillings is minimal. Please check with your provider for benefits.

Patient Signature ______________________________ Date ______________________________