CHILD DENTAL HISTORY

Why have you come to the dentist today? ____________________

Name of child's previous dentist: ____________________ City / State: ____________________

When did child see dentist last? ____________________ Did child have X-rays taken at that time? ❑ Yes ❑ No

What was the reason for child seeking dental treatment at that time? ❑ Routine exam ❑ Teeth cleaning ❑ Special problem

If special problem, please explain: ____________________

Yes	No	
❑	❑	Has child previously complained about dental problems? Please explain: ____________________
❑	❑	Is child extremely nervous or anxious while receiving dental treatment? Please explain: ____________________
❑	❑	Has child had any injuries to the mouth, teeth or head? Please explain: ____________________
❑	❑	Does child have any mouth habits (thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, sippy cup, etc.)? ____________________
❑	❑	Does child have unusual speech habits? Please explain: ____________________
❑	❑	Has child worn orthodontic appliances now or in the past? Please explain: ____________________
❑	❑	Is child assisted with tooth brushing? How often are the child's teeth brushed? _______times daily _______times weekly How often are child's teeth flossed? _______times daily _______times weekly
❑	❑	Does child use toothpaste? What type? ____________________
❑	❑	Is child's drinking water fluoridated?
❑	❑	Is child taking fluoride in any other form? Please explain: ____________________
❑	❑	Has any member of the family ever had an unusual dental history, such as missing or extra teeth? Please explain: ____________________
❑	❑	Does child snack or frequently consume sugar such as gum, soda pop, Life Savers or fruit juices? Please explain: ____________________

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: __________

Doctor's Comments: ____________________

Medical History Update:

1. Date: __________ Comments: ____________________ Signature: ____________________
2. Date: __________ Comments: ____________________ Signature: ____________________
3. Date: __________ Comments: ____________________ Signature: ____________________
4. Date: __________ Comments: ____________________ Signature: ____________________
5. Date: __________ Comments: ____________________ Signature: ____________________
6. Date: __________ Comments: ____________________ Signature: ____________________
7. Date: __________ Comments: ____________________ Signature: ____________________
8. Date: __________ Comments: ____________________ Signature: ____________________

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CHILD HEALTH HISTORY

PARENT/GUARDIAN: The purpose of the following is to determine if your child has a medical condition that may require special care. All information is confidential and kept in your child's dental record. Please complete this form and remain in the dental office while your child is receiving treatment.

Name: ______________________________ Birthdate____/____/____
Child prefers to be called: ______________________________
Date of child's last medical examination: ____/____/____ Current Height: ____________feet ____________inches
Reason: ______________________________ Current Weight: ____________pounds

Medical History

Pediatrician Name: ______________________________
Address ______________________________
____
City State Zip
Phone #: ( ) ______________________________
Child's current physical health is: ❑ Good ❑ Fair ❑ Poor
Is child currently under the care of a physician? ❑ Yes ❑ No
Please explain: ______________________________
____
Does your child use tobacco in any other form? ❑ Yes ❑ No

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin
Y N Barbiturates Y N Jewelry Y N Seasonal
Y N Codeine Y N Latex Y N Sulfa Drugs
Y N Dental Anesthetics Y N Other____________

Please list additional drugs that cause allergic reactions: ____
____
____

For Women: Is child taking birth control pills? ❑ Yes ❑ No
Is child pregnant? ❑ Unsure ❑ Yes, week #:____ ❑ No
Is child nursing? ❑ Yes ❑ No

Is child taking any prescriptions or over-the-counter drugs? ❑ Yes ❑ No
If yes, please list each one: ______________________________

Please indicate if this child has ever been diagnosed or treated for any of the following:

Y N Abnormal Bleeding
Y N Alcohol Abuse/Drug Abuse
Y N Anemia
Y N Arthritis
Y N Artificial Bones/Joints
Y N Artificial Heart Valves
Y N Autoimmune Disease
Y N Asthma
Y N Blood Transfusion
Y N Cancer
Y N Chemotherapy
Y N Colitis/Ulcers
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Emphysema
Y N Epilepsy/Seizures
Y N Fainting Spells
Y N Frequent/Severe Headaches
Y N Glaucoma
Y N Hay Fever
Y N Heart Attack
Y N Heart Murmur
Y N Heart Surgery
Y N Hepatitis Type ______
Y N Herpes/Fever Blisters
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Mitral Valve Prolapse
Y N Pacemaker
Y N Persistent Cough
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Sinus Problems
Y N Steroid Therapy
Y N Stroke
Y N Thyroid Problems
Y N Tuberculosis (TB)
Y N Venereal Disease

List any serious medical condition(s) that the child has experienced:
____

Yes No
❑ ❑ Was child born of a normal 9 month pregnancy? If premature, how many months?_____ Birth weight:_____lbs._____oz.
❑ ❑ Is child physically or mentally handicapped in any way? If yes, how: ______________________________
❑ ❑ Does child need an update on immunizations? Has child ever received general anesthesia or sedation? ❑ Yes ❑ No
❑ ❑ Is child in the grade appropriate for his/her age?

I have answered these questions for the patient (child) to the best of my knowledge and ability.

____
Signature of parent or legal guardian Date

PAYMENT IS DUE IN FULL AT TIME OF SERVICE, INCLUDING ANY DENTAL INSURANCE DEDUCTIBLE AND/OR ESTIMATED PORTION.

Authorization and Release

If you have dental insurance, we will prepare and submit your dental claims as a courtesy to you.

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

I acknowledge that I am financially responsible for all changes whether or not they are covered by insurance. I hereby authorize payment directly to Oswego Dental Care of the group insurance benefits otherwise payable to me. I also authorize release of any information including this diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including rebilling & interest charges, missed appointment fees, all collection costs and reasonable attorney fees. Any accounts sent for collections will be assessed an additional $100 processing fee.

We appreciate your keeping your scheduled appointments. We reserve time & expertise exclusively for you because you are important to us. If you should need to change or cancel your appointment, we kindly ask you give 48 hours notice. Appointments cancelled without 48 hours notice or failed appointments may be assessed a fee of $25 per half hour of scheduled time.

Payment plans and special arrangements must be made ***prior*** to treatment & approved by our office manager. Returned checks will be charged a flat rate of $25.00 per check per incident. Balances older than 60 days from the date of service, regardless of insurance, may be subject to the following interest charges. Interest is calculated at a rate of 1.5% per month (or 18% annually or a $5.00 rebilling fee (whichever is greater)) and applied monthly to unpaid account balances.

For your convenience, we accept most major credit cards. We also offer additional payment plans through an outside financing group. If you would like more information or have any questions, please let us know. We are happy to help.

Name *(Please print)*:____

Signature:____________________________ **Date:** ____________________

Oswego Dental Care
Where you find your smile

Matthew D. Goodhue, DMD

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PHONE: 503.636.6644 • FAX: 503.635.3099

WELCOME

Thank you in advance for your coming to see us today. In order for us to better serve you, please take a few moments to complete this entire form. At Oswego Dental Care, we are committed to keeping your private healthcare information confidential.

Today's Date: ______________________

Person Financially Responsible for Account (parent's name if minor):

Name: ________________________________
Last First Mi Mr Mrs Ms Dr

I prefer to be called: ______________________

❑ Male ❑ Female Birthdate:___/___/___ Age:______

Social Security #: ______________________

Driver's License #: ______________________

Home Address: ______________________
Apt/Condo #

____
City State Zip

❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Phone: (___)________Pager: (___) ________

Work Phone: (___)______________Ext: __________

Cell Phone: (___) ______________________

E-mail: ______________________

Employer:

Employer's Name: ______________________

Employer's Address: ______________________

____
City State Zip

Length of employment: ______________________

Occupation: ______________________

When are the best times to reach you?_____am_____pm

Whom may we thank for referring you? ______________

____

Second Person Responsible for Account/Spouse:

Name:____________________Birthdate:___/___/___

Employer: ______________________

Driver's License #: ______________________

Work Phone: (___)_______Home Phone: (___) _______

Relationship: ______________________

Social Security #: ______________________

Billing Address: ______________________

Primary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone: (___) ______________________

Group Number (Plan, Local or Policy #): ______________

Insured's Name:______________Birthdate:___/___/___

Relationship to Patient: ______________________

Insured's SS #(required): ______________________

Insured Insurance ID #: ______________________

Insured's Employer: ______________________

Employer's Address: ______________________

____
City State Zip

Secondary Dental Insurance

Insurance Co. Name: ______________________

Insurance Co. Address: ______________________

Insurance Co. Phone: (___) ______________________

Group Number *(Plan, Local or Policy #)*: ______________

Insured's Name:______________Birthdate:___/___/___

Relationship: ______________________

Insured's SS #: (required) ______________________

Insured's Employer: ______________________

Employer's Address: ______________________

____
City State Zip

In the event of any emergency, whom should we contact?

Name: ______________________

Relation: ______________________

Work Phone: (___) ______________________

Home Phone: (___) ______________________

Cell Phone: (___) ______________________

Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
Patient Name	Date of Birth	Sex	Age	Social Security Number
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