Cambridge Pediatric Dental Associates

1749 MASSACHUSETTS AVENUE • CAMBRIDGE, MASSACHUSETTS 02140

TEL (617) 491-1161 • **FAX** (617) 661-1555

GENERAL INFORMATION: Date

Patient's Name M☐ F ☐ Nickname

Age Birthdate School Grade

Parents' Names

Home Address City State Zip

Preferred Method Appointment Confirmation Email ☐ Home Phone☐ Cell Phone ☐

Home Phone Cell Phone	Email
Mr./Ms. Employed By	Mr./Ms. Employed By
Occupation City	Occupation City
Business Phone: Mr./Ms.	Mr./Ms.

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Domestic Partner

Person Responsible For Account SSN

Address Phone Number

Dental Insurance Subscriber ID No. Group No. Subscriber DOB

Medicaid ☐ Yes ☐ No Patient's ID No.

Who Referred You To Us

Other Children: Names and Ages

Physician or Pediatrician Address Phone

MEDICAL HISTORY: Has Patient Any History Of The Following:	YES	NO		YES	NO
Rheumatic Fever			Seizures		
Heart Condition Is premedication required?			Bleeding Tendencies		
Heart Murmur			Mental or Emotional Problems		
Liver or Kidney Disease			Allergies		
Easy Bruising			Allergy to Medications		
Diabetes			Medications		
Hospitalization			Surgery		
General Anesthesia			AIDS (HIV positive)		
Hepatitis			Tuberculosis		

Is Patient Presently Taking Medication or Under Medical Care ❑ Yes ❑ No

Last Physical Exam

Comments:

DENTAL HISTORY: Has Patient ever Had:	YES	NO		YES	NO
Previous Dental Care			Topical Fluoride		
Local Anesthesia			Adverse Reactions to Anesthesia		
Dental Extractions			Complications From Any Treatment		
Behavioral Problems			X-Rays - Date of Last:		
Fluoride Tablets or Drops			Nitrous Oxide Analgesia (Gas)		

Has Either Parent Or Any Children A History Of: Orthodontic Problems or Treatment ☐ Yes ☐ No

Congenitally Missing Teeth ☐ Yes ☐ No

PLEASE RETURN THIS FORM AT TIME OF APPOINTMENT