Maria C. Evangelisti, DMD
1 Wallis Ct.
Lexington, MA 02421
339.970.2014

~Please use black ink only~

Patient Information

Patient Name _____ Nickname_____
Date of Birth _____ Sex _____ Hobbies _____
*****Whom may we thank for referring you? _____

Medical History

Child's Physician _____ Date of last exam _____
Phone _____ Address _____
Is your child currently under the care of a physician? **Y/N If yes, please explain**
_____
Is your child currently taking any medications**? Y/N If yes, please explain**
_____
Has your child ever been hospitalized or had surgery? **Y/N If yes, please explain**
_____
Does your child have any allergies to medicines, foods, or other materials? **Y/N If yes, please explain**
_____

Does your child have a history of any of the following: (Please note any significant past medical history not listed here under "other".)

Please circle Y for 'yes' or N for 'no' for each item listed below

Heart trouble or murmurs	Y	N	Asthma	Y	N	Hepatitis	Y	N
Rheumatic Fever	Y	N	Kidney Disease	Y	N	Anemia	Y	N
Seizures/Convulsions	Y	N	Diabetes	Y	N	Cancer	Y	N
Bleeding problems	Y	N	AIDS/HIV	Y	N	Epilepsy	Y	N
Blood Disorders	Y	N	Liver Disease	Y	N	Deafness	Y	N
Premature Birth	Y	N	Lung Disease	Y	N	Other	Y	N

If other, please explain._____

Dental History

Date of last dental exam _____ For what service?_____
Previous dentist _____
Reason for today's visit _____
Has your child experienced any unfavorable reaction from previous medical or dental care? **Y/N If yes, please explain**_____
How do you think your child will act toward the dentist? _____
Has your child had any past injury to head, face, or teeth? **Y/N If yes, please explain**
_____
Has your child complained about a dental problem? **Y/N If yes, please explain**
_____
How often does your child brush? _____ Is the brushing supervised? **Y/N**
Do you floss your child's teeth? **Y/N**
Does your child use fluoride? **Y/N If yes, what kind: Drops / Tablets / Paste / Rinse**
Do you have any other concerns about your child that we should discuss? **Y/N If yes, please explain.**_____

Please turn over and complete

Family Information, Authorization, & Financial Responsibility
<u>*Please fill in completely and sign at bottom***</u>**

Responsible Party
Guarantor Name _____ Date of Birth _____
Social Security # _____ Sex _____ Relationship to Patient _____
Home/Mailing Address _____
City _____ State _____ Zip _____ Home Phone _____
Cell # _____Work #_____Employer_____
E-Mail:_____
Other Parent Information
Name _____ Date of Birth _____
Social Security #_____ Sex _____ Relationship to Patient _____
Mailing Address _____ City_____ State _____ Zip _____
Home # _____Work # _____ Cell #_____Employer_____
E-Mail:_____
Insurance Information
(Please fill in completely and provide a copy of your card.)
Dental insurance name _____ Phone #_____
Claims address _____City _____ State_____ Zip_____
Policy Holder's Name _____ **Date of Birth** _____
Social Security # _____**Relationship to patient** _____
Employer _____ **Policy #**_____ **Group** #_____

Emergency Contact Information (Someone other than immediate family)
Name _____ Relationship_____ Phone #_____

Authorization

By signing below I hereby authorize Dr. Evangelisti and staff to provide dental treatment for my child. I agree to notify the office **immediately** of any changes in the above information and understand that this information will be used to determine appropriate care and treatment for my child. I consent to treatment and medications deemed necessary by the doctor and staff in order to provide the best quality dental care for my child.
I authorize Dr. Evangelisti and staff to release all information necessary to secure payment of benefits and authorize my insurance company to pay the benefits otherwise payable to me and authorize the use of my signature on all insurance claim submissions.
I understand that I am responsible for payment of all services provided and that the office does insurance as a **courtesy.** At the time of visit the office will provide me with an **estimate** of my payment portion based on any available information at that time. If there is a discrepancy between the estimated patient portion and the final balance remaining after insurance payment I understand that I am responsible for the difference and will be billed accordingly. I understand that failure to pay will cause the account to be placed with a collection agency.
<u>Divorce</u>: After a divorce or separation, the parent authorizing treatment for the child will be the parent responsible to us for the subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent. We will not intervene.
<u>Missed or Broken Appointments</u>: Rescheduling an appointment may be done up to 48 hours prior to your scheduled appointment without expense. You will be assessed a $50.00 fee per child for the second missed appointment, and a $100.00 fee per child for the third missed appointment, after which the practice reserves the right to dismiss patients due to repeated rescheduling or missed appointments per family.

Responsible Party _____ **Date** _____