**Providence Pediatric Dentistry**
**111 Point Street**
**Providence, RI 02903**

***BY SIGNING THIS FORM YOU ARE STATING THAT YOU ARE THE PARENT/LEGAL GURADIAN OF THIS CHILD.***

**This personal information is requested to enable us to give you the most consideration of your time and feelings. It is important to have complete answers so that we may give your child personal attention. This information is, of course, confidential. Thank You.**

## PLEASE COMPLETE ALL INFORMATION ON THIS FORM

CHILD'S NAME _____Male___Female___AGE _____ DATE OF BIRTH _____

CHILD'S SS#_____ SCHOOL_____GRADE_____Parent E-MAIL_____

ADDRESS _____CITY _____ST_____ZIP_____

HOME PHONE_____CELL PHONE_____

CHILD'S FAVORITE ACTIVITY_____

MOTHER / FATHER NAME_____ DATE OF BIRTH _____SS#_____

WHERE DO THEY WORK?_____PHONE_____OCCUPATION_____

FATHER / MOTHER NAME_____ DATE OF BIRTH _____SS#_____

WHERE DO THEY WORK?_____PHONE_____OCCUPATION_____

NAME OF CLOSEST RELATIVE_____Relationship_____Phone_____

Child's Physician_____Address_____Phone_____

Date of last complete physical examination?_____Results_____

**MUST READ AND SIGN - LIST** ALL ACTIVE *DENTAL* **POLICIES:**

WHO WILL BE RESPONSIBLE FOR THE ACCOUNT?_____ DO YOU HAVE DENTAL INSURANCE? _____

NAME OF PRIMARY DENTAL INS CO: _____ SUBSCRIBER ID# _____ Group # _____

SUBSCRIBER'S NAME_____ Date of Birth: _____ (Please present card to receptionist.)

NAME OF SECONDARY DENTAL INS CO: _____ SUBSCRIBER ID# _____ Group # _____

SUBSCRIBER'S NAME_____ Date of Birth: _____ (Please present card to receptionist.)

I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ALL DENTAL SERVICES PROVIDED IN THIS OFFICE. PAYMENT IS DUE AT THE TIME THE SERVICE IS PROVIDED UNLESS OTHER ARRANGEMENTS ARE MADE.
I ALSO UNDERSTAND THAT ANY BALANCE NOT PAID BY MY INSURANCE CARRIER IS MY RESPONSIBILTY, AND IS DUE WHEN BILLED BY THIS OFFICE. ANY CLAIMS NOT PAID BY INSURANCE COMPANY WITHIN 60 DAYS BECOMES THE RESPONSIBILITY OF THE SUBSCRIBER UNLESS OTHER ARRANGEMENTS ARE MADE.
I UNDERSTAND THAT SINCE ALL INSURANCE POLICIES VARY, ***IT IS MY RESPONSIBILTY*** TO CHECK WITH MY INSURANCE CARRIER TO DETERMINE WHAT SERVICES ARE COVERED AND ANY LIMITATIONS THAT APPLY.

**Signature of Parent/Legal Guardian:** _____ **Date:**_____

DENTAL HISTORY
HAS YOUR CHILD BEEN SEEN BY ANOTHER DENTIST (INCLUDING SCHOOL DENTIST) IN THE PAST 12 MONTHS? Yes No

HAS YOUR CHILD HAD ANY DENTAL X-RAYS TAKEN IN THE LAST 12 MONTHS? Yes No Explain: _____

DATE OF VISIT _____FOR WHAT?_____BY DR_____

HAS YOUR CHILD COMPLAINED ABOUT ANY DENTAL PROBLEMS/PAIN? Yes No Explain:_____

ANY INJURIES TO MOUTH, TEETH, HEAD? Yes No Explain:_____

ANY MOUTH HABITS–thumb sucking, nail biting? Yes No

**Please Complete Reverse Side**

# MEDICAL HISTORY

All questions asked on the history form are important in arriving at a diagnosis and a treatment plan; all questions must be answered; if any question is not understood, it should be discussed with the doctor; if a medical condition not related to any question on the form is known, it should be reported to the doctor.

IS YOUR CHILD IN GOOD HEALTH? Yes No -If no please explain: _____

IS YOUR CHILD PRESENTLY UNDER CARE BY A PHYSICIAN? (Other than regular well visits) Yes No

If yes please explain:_____

IS YOUR CHILD RECEIVING ANY MEDICATIONS OR DRUGS? Yes No -If yes what are they?

_____

WHAT IS YOUR CHILD'S WEIGHT? _____HEIGHT _____

HAS YOUR CHILD EVER BEEN HOSPITALIZED? Yes No -If yes for what reason? _____

HAS YOUR CHILD EVER HAD SURGERY? Yes No -If yes for what reason? _____

HAS YOUR CHILD EVER HAD BLOOD TRANSFUSIONS? Yes No -If yes for what reason?_____

EATING HABITS PRESENTLY – BRIEFLY EXPLAIN _____

ARE THERE ANY PSYCHOLOGICAL OR EMOTIONAL PROBLEMS YOU WOULD LIKE TO BRING TO OUR ATTENTION? Yes No

-If yes for what reason? _____

| DOES YOUR CHILD HAVE OR HAS HE/SHE HAD ANY OF THE FOLLOWING HEALTH PROBLEMS? | YES | NO |
|---|---|---|
| 1) RHEUMATIC FEVER OR RHEUMATIC HEART DISEASE_____ | ☐ | ☐ |
| 2) CONGENITAL HEART DISEASE OR HEART MURMUR _____ | ☐ | ☐ |
| 3) ALLERGIES: Please Specify_____ | ☐ | ☐ |
| 4) ASTHMA _____ | ☐ | ☐ |
| 5) ARTHRITIS OR RHEUMATISM (PAINFUL SWOLLEN JOINTS) _____ | ☐ | ☐ |
| 6) DIABETES OR BLOOD SUGAR PROBLEMS _____ | ☐ | ☐ |
| 7) ANY PROLONGED BLEEDING OR BRUISES EASILY _____ | ☐ | ☐ |
| 8) KIDNEY OR BLADDER PROBLEMS _____ | ☐ | ☐ |
| 9) ANEMIA OR BLOOD DISORDERS _____ | ☐ | ☐ |
| 10) TUBERCULOSIS OR PNEUMONIA _____ | ☐ | ☐ |
| 11) LIVER PROBLEMS, JAUNDICE OR HEPATITIS _____ | ☐ | ☐ |
| 12) AUTISM_____ | ☐ | ☐ |
| 13) GLANDULAR OR HORMONAL PROBLEMS _____ | ☐ | ☐ |
| 14) ACCIDENTS OR SEVERE INFECTIONS _____ | ☐ | ☐ |
| 15) CONVULSION, SEIZURES, FAINTING OR EPILEPSY_____ | ☐ | ☐ |
| 16) HIGH/LOW BLOOD PRESSURE _____ | ☐ | ☐ |
| 17) SPEECH, LEARNING OR HEARING DISORDERS_____ | ☐ | ☐ |
| 18) OTHER, IF SO EXPLAIN _____ | ☐ | ☐ |

**"I UNDERSTAND THAT THE INFORMATION PROVIDED ON THIS FORM IS ESSENTIAL TO DETERMINE MY/MY CHILD'S DENTAL NEEDS AND THE PROVISIONS OF DENTAL TREATMENT. I UNDERSTAND THAT IF ANY CHANGE OCCURS IN MY/MY CHILD'S HEALTH THAT I AM TO REPORT IT TO THE DENTAL OFFICE AS SOON AS POSSIBLE. I HAVE READ AND DO UNDERSTAND EACH QUESTION AND HAVE ANSWERED ALL OF THE QUESTIONS TRUTHFULLY AND TO THE BEST OF MY ABILITY. I HAVE DISCUSSED MY HEALTH HISTORY WITH THE DOCTOR."**

**I hereby grant authority to: Thomas S. Mulvey, DDS, LLC, Thomas S. Mulvey, DDS and/or Farisa S. Mulvey, DDS of 148 Waterman Street, Providence, RI 02906 to administer any treatments and to perform such procedures as may deemed necessary or advisable in the diagnosis and treatment of this patient only with the prior consent of either the parent or legal guardian.**

_____ _____

**SIGNATURE of Parent or Legal Guardian** **Date**