Convivial Dental, P.C.

1244 Boylston Street
Chestnut Hill, MA 02467
Tel. (617) 735-0800
Fax (617) 735-0801

Date______________________

Your Child

Child's Name________________________________
Last Name First Name Initial
Nickname________________________ Sex☐M ☐F
Birthdate________________________Age________
Child's Home Address_________________________
City_______________________State____Zip______
Phone______________________________________

Person Accompanying Child Today

Name______________________________________
Last Name First Name Initial
Relationship to child__________________________
Siblings & Ages_____________________________
____
Whom may we thank for referring you?_____________
____

Mother ☐ *Stepmother* ☐ *Guardian* ☐ *Other* ☐

Name______________________________________
Last Name First Name Initial
Address____________________________________
(If Different from child's)
City_______________________State____Zip_______
Home #________________Cell #__________________
Work # ____________________________________
E-mail_____________________________________
Employer___________________________________
Occupation_________________________________
SS #_______________________DOB______________
☐Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Father ☐ *Stepfather* ☐ *Guardian* ☐ *Other* ☐

Name______________________________________
Last Name First Name Initial
Address____________________________________
(If Different from child's)
City_______________________State____Zip_______
Home #________________Cell #__________________
Work #_____________________________________
E-mail_____________________________________
Employer___________________________________
Occupation_________________________________
SS #_______________________DOB______________
☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Primary Dental Insurance

Subscriber's Name___________________________
Relationship to child_________________________
Birthdate__________SS #______________________
Employer__________________________________
Insurance Company___________________________
Group #______________ID #____________________

Additional Dental Insurance

Subscriber's Name___________________________
Relationship to child_________________________
Birthdate__________SS #______________________
Employer__________________________________
Insurance Company___________________________
Group #____________ID # ______________________

(OVER)

MEDICAL HISTORY

Physician's Name____ Date of Last Physical______________________

Physician's Address____

Does your child have any major physical and/or mental handicaps?____

Has your child ever had any serious illnesses or operations?___________ If yes, please describe___________________________

____

Has your child ever responded adversely to medical or dental treatment?____

Has your child ever had any of the following? (check boxes that apply):

- ☐ Abuse (Physical or Sexual)
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Autism
- ☐ Bleeding (Prolonged)
- ☐ Brain Injury
- ☐ Cancer: Type__________________
- ☐ Cerebral Palsy
- ☐ Cleft Lip/Palate
- ☐ Diabetes
- ☐ Emotional Disability
- ☐ Fainting (Frequent)
- ☐ Gastrointestinal Disorders
- ☐ Hearing Loss: Type_______________
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Leukemia: Type________________
- ☐ Mental Deficiency
- ☐ Nutritional Deficiency
- ☐ Orthopedic Problems
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sickle Cell Trait or Disease
- ☐ Snoring (Sleep Apnea)
- ☐ Speech Problem: Type___________
- ☐ Spina Bifida
- ☐ Syndrome: Type________________
- ☐ Transfusion (Blood): When_________
- ☐ Other_________________________

Is there anything else we should know about your child's medical history?____

MEDICATIONS

Please list any medications your child is currently taking:

____

____

Pharmacy Name____

Phone_(_______)____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates (Sleeping Pills)
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other_________________

____

SIGNATURES

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, being the parent or legal guardian, have provided insurance information for use by this office, and hereby assign directly to Dr. A. Zavras and Convivial Dental doctors all benefits, if any, otherwise payable to me for services rendered. I also hereby authorize the doctor to release all information necessary to secure the payment of benefits and the use of this signature on all insurance submissions whether manual or electronic.

______________________ **X**____

Date Signature

PARENT/LEGAL GUARDIAN CONSENT

I, being the parent or legal guardian, do hearby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor.

______________________ **X**____

Date Signature of Parent/Guardian

FINANCIAL AGREEMENT

I agree that parents/guardians are responsible for all co-payments, patient percentages, deductibles, and balances. I accept full financial responsibility for all charges not covered by insurance.

______________________ **X**____

Date Signature of Parent/Guardian