# Dentistry for Children
# Rachel A. Maher, DMD, PA

**2036 Foulk Road * Suite 200 * Wilmington, DE 19810 * 302-475-7640**

## Patient Information

We welcome your child into our practice and we will try to make his/her dental experiences pleasant.
Please complete this form so we may better understand and care for your child.

Patient Name: _____ Nickname: _____
Last First MI

☐ Male ☐ Female Birth Date: _____ Age: _____

Parent/Guardian: _____

Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

Telephone #: (Home) _____ (Cell) _____

Last Dental Visit: _____ Xrays: _____ Dentist: _____ Referred by: _____

## Health Information

**Has your child had or currently have any of the following? Please check those that apply:**

☐ ADD/ADHD
☐ Allergies/Environmental
_____
_____
_____
☐ AIDS
☐ Anemia
☐ Asthma
☐ Autism
☐ Behavioral Disorders
☐ Blood Disease
☐ Cancer
☐ Central line/Medi-Port
☐ Cerebral Palsy
☐ Development Delays
☐ Diabetes
☐ Excessive bleeding
☐ Fainting
☐ Head Injuries
☐ Hearing Loss
☐ Heart Arrhythmia
☐ Heart Disease
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Medications _____
_____
_____
☐ Mental Disorders
☐ Nervous Disorders
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Seizures
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Codeine Allergy
☐ Penicillan Allergy
☐ Food Allergy
☐ Latex Allergy
☐ Other: _____
_____
_____

*Has your child had any past surgeries? ☐ Yes ☐ No
_____
*Has your child been admitted to a hospital or needed emergency care during the past 3 years? ☐ Yes ☐ No
_____
*Name of Pediatrician: _____ Last visit: _____ Phone: _____
*Has your child had an unfavorable dental experience? ☐ Yes ☐ No
_____
*Does your child have a current or past history of: thumb or finger sucking _____ pacifier _____
*Was your child breast fed? _____ Bottle fed? _____ Age discontinued: _____
*What is your water source? Public system _____ Private Well _____ Bottled Water _____

To the best of my knowledge, all of the information provided is true and correct. It is my responsibility to inform this office of any changes in my child's medical status. I authorize Dr. Rachel A. Maher and the dental staff of Dentistry for Children to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian Date

Rev. 07/2013

# Dentistry for Children


## Rachel A. Maher, DMD, PA

2036 Foulk Road * Suite 200 * Wilmington, DE 19810 * 302-475-7640 * (Fax) 302-475-1700


**Personal Information:** Patient Name _____
Parent/Guardian Name _____
Address _____
Apartment/Suite# _____
City, State, Zip _____

**Contact Information:** Home _____ Cell _____ Text Y / N
Work _____ E-mail _____

**Referral Information:** How did you hear about our office? _____
(Doctor's name, friend's name, telephone book, internet, advertisement, etc.) *Please be specific.*

**Emergency Contacts:** Name/Relationship _____ Phone _____
Name/Relationship _____ Phone _____

**Dental Insurance:** Name of Insured _____ DOB _____
Employer _____
Ins. Company _____ Phone _____
Ins. Co. Address _____
SS / ID # _____ Group # _____

**Authorization:** I agree to be responsible for all charges for dental services, consultations, and materials at the time of the visit. I understand all insurance claims will be submitted on my behalf and the insurance reimbursement will be paid directly to me as determined by my individual policy. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with all insurance claims.

_____ _____
**Parent/Guardian Signature** **Date**

**Medicaid Insurance:** Name on Card: _____ Medicaid # _____
Do you have any other insurance besides Medicaid? Yes / No
If yes, who? _____
Please complete Dental Insurance section above.

***I understand that if Medicaid does not pay, I will be responsible for payment of services. All Medicaid patients must present their Medicaid card and a photo ID for mother/father at each appointment. A copy will be kept in the patient's chart.***

_____ _____
**Parent/Guardian Signature** **Date**

Rev 4/2012