Southern Maine Pediatric Dentistry

Dr. Whitney Wignall | Dr. Aaron Schmick

1601 Congress Street, Portland, Maine 04102
Phone: (207)773-3111 Fax: (207)773-3133

Patient Name: _____ **Age:**_____

Would you like to receive e-mail confirmation of your appointment?

- ❑ YES E-mail :_____
- ❑ NO

Patient Dental Insurance:

YES/NO: I certify that the information shown to me regarding my child's insurance is correct.

Dental and Health History Update:

Do you have any ***DENTAL CONCERNS*** to discuss at this visit? _____

❑ ***CHECK HERE*** if there are ***NO*** changes to your child's health history, and ***SIGN*** below.

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1) Your child's physician has changed in the last 12 months.
Name of ***NEW*** Physician:_____ Phone Number:
_____

2) Your child's health history has changed in the last 12 months. Please check all that apply.

Please check if your child has been diagnosed and/or treated for any of the following:

☐ AIDS/HIV	☐ Diabetes	☐ Hepatitis	☐ Tuberculosis	☐ Mental delays
☐ Anemia	☐ Epilepsy / Seizures	☐ Kidney Disease	☐ Congenital birth defects	☐ Physical delays
☐ Asthma	☐ Excessive Bleeding	☐ Liver Disease	☐ Cerebral palsy	☐ Social delays
☐ Blood Disorder Transfusion	☐ Frequent Headaches	☐ Rheumatic fever	☐ Cleft lip / palate	☐ Speech / hearing problems
☐ Cancer / Tumors	☐ Heart Condition / Murmur	☐ Stomach / GI disease	☐ Frequent infections	☐ Other

❑ Autism, ADD, ADHD, Aspergers (please circle one or more)

3) Your child has ***NEW*** allergies. Please list ***NEW*** allergies and reaction:
_____

4) Is your child taking any ***NEW*** medication (including inhalers, and EPI pens) or has the dose of any current medications changed?
Please list ***NEW*** medication and dose:
_____
_____

5) Has your child has been hospitalized or visited the Emergency Room in the last 12 months? Please explain below.
_____

I certify that all the above information is accurate. Since your child is a minor, it is necessary that signed permission is obtained from a parent or legal guardian prior to any treatment being rendered by Dr. Wignall or Dr. Schmick. I understand I will be consulted prior to any treatment being rendered. I also authorize the use of photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching,

research, and scientific publication. I authorize the release of this information to those individuals requiring it for the purpose of treating my child. I further understand that this consent will remain in effect until I choose to terminate it.

Signature: _____Relationship to Patient:_____
Date:_____

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