DR. MELISSA M. BEAUDET-UY
GENERAL DENTISTRY LIMITED TO CHILDREN AND TEENS

MELISSA M. BEAUDET-UY D.D.S.

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New Patient Pre-Appointment Check-List

Welcome to our practice. We want to make sure your first visit to our office is an exceptional one. To help us meet your expectations please use this checklist to make sure we have all of the information we will need for your visit.

- Contact your previous dentist and ask them to send your records to the office email: beaudetdds@gmail.com
- Complete the new patient health history form **before you arrive** and **bring it with you to the appointment.**
- **Arrive 15 minutes before** your scheduled time to complete additional paperwork.
- Bring your insurance card if one was issued
- Please be sure you have the following information for the person who carries the insurance for the child.
    - Insured's Name, Address & Phone Number
    - Insured's Date of Birth
    - Insured's Plan, Member ID# or SSN
    - Insured's Group Number
    - Insured's Employer
- Payment is expected at the time of service. For your convenience, we accept cash, personal checks, VISA, MasterCard, American Express, Discover or Care Credit. As a courtesy we will submit your insurance claim.
- A parent and/or legal guardian **must** accompany the child to their initial visit

We look forward to meeting you!

Dr. Beaudet-Uy and Staff

Dr. Beaudet-Uy's Health History Form

1. Tell us about your child

Child's Name: _____
Goes by: _____ Sex: M F
Names & Ages of Siblings: _____
_____
Child's Birthday ___/___/___ Child's Age: _____
School _____ Grade_____
Reason for Visit: _____
_____
_____

2. Mother's Information

Name_____
Circle one: Mother Stepmother Guardian
Birthdate ___/___/___ Marital Status:_____
Employer:_____
Home #_____ Cell #_____
Work #_____ Ext._____
Home Address_____
_____

3. Father's Information

Name_____
Circle one: Father Stepfather Guardian
Birthdate ___/___/___ Marital Status: _____
Employer:_____
Home #_____ Cell #_____
Work #_____Ext. _____
Home Address _____
_____

4. With whom does your child reside?

_____

5. We confirm appointments by text and email

Cell number(s) to text to _____
_____
Email address_____
_____

6. Who may we thank for referring you to our office?

_____

7. Primary Dental Insurance

Insurance Company Name _____
_____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____
Group # _____ ID #_____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthday ___/___/___
Policy Owner's Employer_____

8. Secondary Dental Insurance

Insurance Company Name _____
_____
Insurance Co. Address _____
_____
Insurance Co. Phone # _____
Group # _____ ID #_____
Policy Owner's Name _____
Relationship to Patient _____
Policy Owner's Birthday ___/___/___
Policy Owner's Employer_____

9. Dental History

Is this your child's first visit to the dentist? _____
If not, how long since the last visit to the dentist?

_____
Previous Dentist's name & number _____

_____
Were any x-rays taken at previous Dentist? _____
Have there been any injuries to the teeth, face or mouth? _____ If yes, please explain _____

_____
How do you expect your child to act at this visit?

_____

_____

Does your child have any of the following habits?
Circle: Lip Sucking/Biting Nail Biting

Thumb/Finger Sucking Grind Teeth

Clench Jaws Nursing/Bottle Habits

Has your child ever had a serious or difficult problem associated with previous dental work?

_____

Is your child's water fluoridated?	Yes	No
Is your child taking fluoride supplements?	Yes	No
Does your child brush his/her teeth daily?	Yes	No
Does your child floss daily?	Yes	No

10. Health History

Has your child ever had any of the following conditions? (Please circle)

Abnormal bleeding	Convulsions	Hepatitis
Allergy to Dyes	Developmental Delay	HIV/AIDS
Allergy to Latex	Diabetes	Kidney/Liver Disease
Asthma	Handicaps/Disabilities	Pacemaker
Autism	Hearing/Speech Impaired	Respiratory Disease
Bleeding Disorder	Heart Disease	Rheumatic Fever
Cancer	Heart Murmur	Thyroid Disease
Cerebral Palsy	Hemophilia/Blood Disorders	Tuberculosis

If no conditions above are circled initial here _____
If heart murmur was circled, does your child require premedication? _____
Please discuss any other medical conditions/surgeries/ hospital stays your child has had _____

_____
Please list all medications your child is currently taking

_____

_____
Please list the child's allergies including medications, latex, dyes, ect. _____

_____
Child's Physician_____ Number_____
Child's Cardiologist _____ Number_____
Is the child currently under the care of a physician?
Yes No
If yes, please explain_____

_____

☐ I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need. This consent shall remain in effect until cancelled by the parent or guardian. I agree to be responsible for the payment of all rendered treatment on behalf of my dependents.
☐ I have been offered a copy of the office's Notice of Privacy Practice.
☐ I choose not to receive the copy of the office's Notice of Privacy Practice.

_____ _____ _____
Signature of Parent or Guardian Date Relationship to Patient

Medical History Update

Date _____ Comments _____

No Changes ( ) Parent Signature _____

Date _____ Comments _____

No Changes ( ) Parent Signature _____

Date _____ Comments _____

No changes ( ) Parent Signature_____

Date _____ Comments _____

No changes ( ) Parent Signature_____

Date _____ Comments _____

No changes ( ) Parent Signature_____

Date _____ Comments _____

No changes ( ) Parent Signature_____

Date _____ Comments _____

No changes ( ) Parent Signature_____

Date _____ Comments _____

No changes ( ) Parent Signature_____