Welcome to Berkshire Pediatric Dentistry. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Child's Name: _____ Today's Date:_____
Last First MI

Nickname_____ ☐ Male ☐ Female Child's Age____ Child's Birth Date: _____

School_____Grade_____ Child's Home Phone #: ( ) _____

Child's Home Address:

_____
Street Apartment #

_____
City State Zip Code

Email Address: _____

Who is accompanying the child today? _____Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No Does DCF have legal custody of this child ? ☐ Yes ☐ No

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered ☐ Separated

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ Radio ☐ Pediatrician ☐ Other_____

Name of person or office referring you to our practice:_____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Reason for this visit: _____

Person responsible for making appointments?

Name: _____

Work #:_____Home #:_____Cell Phone #:_____

Guardian 1: Name:_____ Relation: _____

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Social Security #: _____Birth date: _____

Work #:_____Home #:_____Cell Phone#:_____

Guardian 2: Name:_____ Relation: _____

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Social Security #: _____Birth date: _____

Work #:_____Home #:_____Cell Phone #:_____

Dental Insurance Information

Primary

Insurance Co. Name and Address: _____

_____

Insurance Co. Phone #: _____

Policy Owner's Name: _____ Relationship to patient _____
Last First MI

Policy Owner's Birth Date: _____ ID#:_____ Group #:_____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

Secondary

Insurance Co. Name and Address: _____

_____

Insurance Co. Phone #: _____

Policy Owner's Name: _____ Relationship to patient _____
Last First MI

Policy Owner's Birth Date: _____ ID#:_____ Group #:_____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

- Does the child brush his/her teeth daily? ☐ Yes ☐ No Floss his/her teeth daily? ☐ Yes ☐ No
- Take fluoride supplements? ☐ Yes ☐ No Is the child currently under the care of a physician? ☐ Yes ☐ No

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient insurance company as a service to our patients. This office will prepare the patients insurance forms and assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Any balance not paid by the insurance company will be billed to the patient/parent.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party

DR. LISA GAMACHE
DR. NEHA DAS
BOARD CERTIFIED PEDIATRIC DENTISTS

BERKSHIRE PEDIATRIC DENTISTRY

77 Elm Street
Pittsfield, MA 01201
413-442-0122

Medical History Form

Child's Name: _____ DOB: _____ Today's Date: _____

Physician's Name: _____ Pharmacy: _____

Are immunizations up to date? Yes / No

YOUR **CHILD** EVER BEEN DIAGNOSED WITH THE FOLLOWING CONDITIONS? (Please answer yes/no for ALL options)

Y	N	
		ADD/ADHD (circle one)
		Anemia
		Anxiety
		Arthritis
		Asthma
		Autism Spectrum Disorder
		Bladder Conditions
		Blood Transfusions
		Birth Defects
		Bone/Orthopedic Problems
		Brain Injury
		Cancer
		Cerebral Palsy
		Child Abuse
		Chronic Adenoid/Tonsils
		Chronic Headaches/Migraine
		Chronic Ear Infections
		Cleft Lip/Palate

Y	N	
		Congenital Heart Disease
		Convulsions/Seizures
		Diabetes
		Emotional Disturbances
		Epilepsy
		Eye Problems
		Excessive Gagging
		Fainting/Dizziness
		Growth/Development Issue
		Handicap/Disability
		Hearing/Speech Problems
		HIV/AIDS
		Heart Murmur/Defects
		Hemophilia/Excess Bleeding
		Hepatitis or Liver Disease
		Intellectual Disability
		Kidney Disease
		Leukemia

Y	N	
		Malignant Hyperthermia
		Nutritional Deficiency
		Pacemaker
		Pregnancy
		Premature Birth
		Psychiatric Issues/Treatment
		Reflux/Stomach Problems
		Respiratory Problems
		Rheumatic Fever
		Scoliosis
		Sensory Disorder
		Sickle Cell Anemia
		Sinus Problems
		Stroke
		Syndrome:
		Tuberculosis
		Tumors
		Ulcers

Other:

Surgeries (date and type):

Please list all **medications** _____

Allergies? Yes / No *If yes, please circle:* Local Anesthetic Penicillin/Amoxicillin Sulfa Latex Peanuts Tree Nuts

Other: _____

Parent's Signature _____ Dentist's Signature _____

Date _____ Date _____

DR. LISA GAMACHE
DR. NEHA DAS
BOARD CERTIFIED PEDIATRIC DENTISTS

BERKSHIRE
PEDIATRIC DENTISTRY

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Informed Consent for General Dental Procedures

You, on behalf of the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless you have discussed all potential benefits, risks, and complications with your dentist and all questions you may have are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and sign the bottom of the form:

1. **Treatment to be provided:** I understand that during the course of treatment that the following care may be provided: Examinations, preventive services including sealants, x-rays, and restorations
   Services like: Crowns, extractions, and the use of nitrous oxide (laughing gas) require consent from a guardian at the time of treatment

2. **Drugs and medications:** I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues, pain itching, vomiting, and/or anaphylactic shock (severe allergic reaction)

3. **Changes in treatment plan:** I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being pulp therapy following routine restorative procedures. I give my permission to the dentist to make any and all changes and additions and necessary.

Parent/Guardian Signature _____ Date _____