

**Children's Dental Care**

Blake Wullbrandt, DDS

**PATIENT INFORMATION**

Today's Date \_\_\_\_\_

Patient's Full Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Date of Birth \_\_\_\_\_ Interests/Hobbies \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**Responsible Party:**       Mother       Father       Guardian       Other \_\_\_\_\_**Mother's Name** \_\_\_\_\_ Birth Date \_\_\_\_\_ Occupation \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Father's Name** \_\_\_\_\_ Birth Date \_\_\_\_\_ Occupation \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Emergency Contact (other than parent):** \_\_\_\_\_ Relationship to child \_\_\_\_\_ Phone \_\_\_\_\_**Methods of Contact:**

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Parent E-mail address \_\_\_\_\_

Preferred Method of Contact for reminder calls (**Check One**):      \_\_\_\_\_ Home      \_\_\_\_\_ Cell (text)      \_\_\_\_\_ E-mail**DENTAL INSURANCE INFORMATION****State Provided Insurance:**

NH Medicaid (11 digit number): \_\_\_\_\_ VT Medicaid (number): \_\_\_\_\_ Mass Health (number): \_\_\_\_\_

**Private Insurance:****Policy Holders Name** \_\_\_\_\_ SS# \_\_\_\_\_ Subscriber # \_\_\_\_\_

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

Employers Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Insurance Company \_\_\_\_\_ Ins. Phone Number \_\_\_\_\_

**SECONDARY COVERAGE:****Policy Holders Name** \_\_\_\_\_ SS# \_\_\_\_\_ Subscriber # \_\_\_\_\_

Employer \_\_\_\_\_ Group Number \_\_\_\_\_

Employers Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Insurance Company \_\_\_\_\_ Ins. Phone Number \_\_\_\_\_

**Health Information**

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_

Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_

Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_

Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_

Are you on a special diet?  Yes  No

Do you use tobacco?  Yes  No

Do you use controlled substances?  Yes  No

Women: Are you  
 Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No	Hemophilia <input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No	Diabetes <input type="radio"/> Yes <input type="radio"/> No	Hepatitis A <input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No	Drug Addiction <input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No
Anemia <input type="radio"/> Yes <input type="radio"/> No	Easily Winded <input type="radio"/> Yes <input type="radio"/> No	Herpes <input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No
Angina <input type="radio"/> Yes <input type="radio"/> No	Emphysema <input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Rheumatism <input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No	High Cholesterol <input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No	Hives or Rash <input type="radio"/> Yes <input type="radio"/> No	Shingles <input type="radio"/> Yes <input type="radio"/> No
Artificial Joint <input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No
Asthma <input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No
Blood Disease <input type="radio"/> Yes <input type="radio"/> No	Frequent Cough <input type="radio"/> Yes <input type="radio"/> No	Kidney Problems <input type="radio"/> Yes <input type="radio"/> No	Spina Bifida <input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No	Leukemia <input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No
Breathing Problem <input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No	Liver Disease <input type="radio"/> Yes <input type="radio"/> No	Stroke <input type="radio"/> Yes <input type="radio"/> No
Bruise Easily <input type="radio"/> Yes <input type="radio"/> No	Genital Herpes <input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No
Cancer <input type="radio"/> Yes <input type="radio"/> No	Glaucoma <input type="radio"/> Yes <input type="radio"/> No	Lung Disease <input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No
Chemotherapy <input type="radio"/> Yes <input type="radio"/> No	Hay Fever <input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No	Tonsillitis <input type="radio"/> Yes <input type="radio"/> No
Chest Pains <input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No	Tuberculosis <input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No	Heart Murmur <input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No	Ulcers <input type="radio"/> Yes <input type="radio"/> No
Convulsions <input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No	Venereal Disease <input type="radio"/> Yes <input type="radio"/> No
			Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**DENTAL INFORMATION**

Has child ever seen a dentist? Yes / No Name \_\_\_\_\_ Date \_\_\_\_\_

Has child had any unfavorable dental experiences? Yes / No \_\_\_\_\_

Has child had any injuries to mouth or teeth? Yes / No \_\_\_\_\_

Has child recently had a toothache? Yes / No \_\_\_\_\_ When? \_\_\_\_\_

Does child have any of the following habits? (circle) thumb sucking, pacifier, nail biting, mouth breathing

**AUTHORIZATION TO TREAT**

I hereby authorize payment directly to Blake Wullbrandt, DDS of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Blake Wullbrandt, DDS to administer such medications and perform such diagnostic, photographic, and therapeutic procedures as may be necessary for proper dental care. The information on this form is correct to the best of my knowledge. I grant the right to the dentist to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or other health professionals. In the event should your account be turned over to our collection agency for non-payment, there will be a 30% increase added to your balance to defray the costs the collection agency charges us.

Signature \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ Date \_\_\_\_\_

# Children's Dental Care

Blake Wullbrandt, DDS

## Broken Appointment Policy

We want to thank you for choosing us as your dental health care provider. In order to give you the best possible care we request that you review our policy regarding broken appointments.

### What is a broken appointment?

An appointment is considered broken due to any of the following:

1. The patient doesn't come to the appointment.
2. The patient is more than 15 minutes late for the appointment.
3. The patient cancels without giving reasonable notice. We ask for 24-hours notice to reschedule.

### What happens if you break an appointment?

It is our policy not to accept patients who do not show for their **first scheduled appointment**.

An established patient family that breaks more than **2 appointments within 2 years** will be dismissed from our practice and will need to establish with another dental office.

If the appointment missed was scheduled for a **prime time (3:00 or after)**, we will not be able to schedule another late afternoon slot until the next appointment is kept.

If more than three children in a family missed their appointments on the same day, we will not be able to schedule the whole family together in the future.

### Are there any exceptions to these rules?

There may be exceptions to our broken appointment policy. **The best thing to do is to keep our staff informed.** Please give us a call 24 hours in advance, or as soon as you discover the need to change an appointment. If your family misses an appointment, call us within a day to reschedule.

If you are an established family with our practice and are dismissed, Dr. Wullbrandt, by law, will be available to handle emergencies only for **30 days starting from the date of our dismissal letter**. This will allow you time to find a new dentist to care for your children.

### Please Note:

As a courtesy we make every attempt through postcards and phone calls to remind you of upcoming visits. If your address or phone number changes please update us so that you can continue to receive these reminders. Please remember that you, as the responsible party, are ultimately responsible for your child's appointment/s and as such we respectfully ask that you take a moment to record appointments on your calendar or in your phone.

113 Railroad Street Keene, NH 03431 • 603-357-6385 • [www.drwully.com](http://www.drwully.com)

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✂ Please fill out and detach the bottom portion and return to Children's Dental Care. ✂

***I have read and understand the broken appointment policy stated above:***

Children's Names: \_\_\_\_\_

Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Guardian Name: \_\_\_\_\_