Polished, LLC Health History

Child's Name:	<u>Child's Information</u> (Please print): Child's Name:			M - E - Child'o Bi	irthdour /	1
School: Grade: Room: Teacher: Child's primary language: Parent's name and address: Parent's name and address: Parent's name and address: Parent's name and address: Parent's day time phone: Period to the state of t	(first)	(last)				
Child's primary language: Parent's primary language: Parent's horizont primary language: Parent's horizont primary language: Parent's day time phone: Denat Information: 1. Date of last dental check-up: 2. My child has a local dentits YES NO Dentist name: If not, we will provide a list of dentits in your area. 3. My child needs to take antibiotics before having dental treatment YES Why? NO NO Please tell us about your child's dental experience. NO NO NO NO NO NO NO N	School:	Grade:	Room:	Teacher:	(month) (day)	(birtir year)
Parent's hame and address:	Child's primary language:	Pare	ent's primar	v landnade. 		
Parent's day time phone: Dental Information:	Parent's name and address:	i di	onto pinna.	y language		-
Dental Information: Date of last dental check-up:	Email	Pare	ent's day tin	ne phone:		
1. Date of last dental check-up: If not, we will provide a list of dentists YES NO Dentist name: If not, we will provide a list of dentists in your area. 3. My child needs to take antibiotics before having dental treatment YES Why? NO 4. Please tell us about your child's dental experience. Medical Information:	Dental Information:	r ur	one o day un	io priorio:		
1. My child has had serious health problems YES	 My child has a local dentist YES If not, we will provide a list of dentises. My child needs to take antibiotics be a Please tell us about your child's dentity. 	NO □ Dentist nar ts in your area. efore having dental	I treatment	□YES Why?	□ N	10
2. My child is under a doctor's care now. YES for 3. My child has now or had before: Anemia Asthma Convulsions Diabetes Epilepsy Seizures Glaucoma Heart Problems: Heart Murmur Heart valve replacement Hepatitis Kidney/ Liver Rheumatic Fever Joint replacement Immune Disorder /HIV AIDS Tuberculosis Other: 4. My child is taking medicine YES name of medicine 5. My child is allergic to: Penicillin Antibiotics Aspirin Latex Foods Other: Other Demographic Information: The following information is for the Commonwealth of Massachusetts. My child is Back/ African American White Asian American Indian/Alaskan Native Native Hawaiian/ Pacific Islander Hispanic More than one race I do not wish to answer Insurance Information My child has the following dental insurance: MassHealth RID Number: Delta BC/BS Other Individual Policy# Group Policy # Subscriber Information Subscriber Name: Subscriber Date of Birth: Month Day Year I agree that the above health information is correct. I give permission for Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC to glimake every attempt to NOT impact your regular dental checkups, by checking claims history prior to billing for any services. Contact: Ellen Gould RDH MPA email: polishedcheckin@gmail.com; phone (508) 237-5378. SIGN HERE Parent/Guardian:						
5. My child is allergic to: Penicillin Antibiotics Aspirin Latex Foods Other:	 My child is under a doctor's care not My child has now or had before: An Glaucoma ☐ Heart Problems:☐ Fever ☐ Joint replacement ☐ Imn 	ow. YES □ for emia □ Asthma □ leart Murmur □ He nune Disorder /HIV	☐ Convulsio eart valve re // AIDS ☐ T	ns	osy	Rheumatic
Other Demographic Information: The following information is for the Commonwealth of Massachusetts. My child is: Black/ African American White Asian American Indian/Alaskan Native Native Hawaiian/ Pacific Islander Hispanic More than one race I do not wish to answer Insurance Information My child has the following dental insurance: No Dental Insurance MassHealth RID Number: Delta BC/BS Other Individual Policy# Group Policy # Subscriber Information Subscriber Name: Subscriber Date of Birth: Month Day Year I agree that the above health information is correct. I give permission for Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC will make every attempt to NOT impact your regular dental checkups, by checking claims history prior to billing for any services. Contact: Ellen Gould RDH MPA email: polishedcheckin@gmail.com; phone (508) 237-5378. SIGN HERE Parent/Guardian:						
The following information is for the Commonwealth of Massachusetts. My child is: Black/ African American White Asian American Indian/Alaskan Native Native Hawaiian/ Pacific Islander Hispanic More than one race Industrial Industrial Industrial Insurance No Dental Insurance MassHealth RID Number: Delta BC/BS Other Individual Policy# Group Policy # Subscriber Information Subscriber Name: Subscriber Date of Birth: Month Day Year I agree that the above health information is correct. I give permission for Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC will make every attempt to NOT impact your regular dental checkups, by checking claims history prior to billing for any services. Contact: Ellen Gould RDH MPA email: polishedcheckin@gmail.com; phone (508) 237-5378. SIGN HERE Parent/Guardian:	5. My child is allergic to: Penicillin	Antibiotics Asp	ırın 🗀 Late	x L Foods L Other:		
SubscriberEmployer Name:Subscriber Date of Birth: Month Day Year I agree that the above health information is correct. I give permission for Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC will make every attempt to NOT impact your regular dental checkups, by checking claims history prior to billing for any services. Contact: Ellen Gould RDH MPA email: polishedcheckin@gmail.com; phone (508) 237-5378. SIGN HERE Parent/Guardian:	The following information is for the Con My child is: Black/ African American Native Hawaiian/ Pacific Islander I do not wish to answer Insurance Information My child has the following dental ins No Dental Insurance MassHealth RID Number: Delta BC/BS Other Individual Policy# Group Policy # Subscriber Information	White Hispanic Hispan	Asian ☐ More tha	American Indiar an one race FirstName MI LastName 000000000000000000000000000000000000	建版 / 健康	
I agree that the above health information is correct. I give permission for Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC will make every attempt to NOT impact your regular dental checkups, by checking claims history prior to billing for any services. Contact: Ellen Gould RDH MPA email: polishedcheckin@gmail.com ; phone (508) 237-5378. SIGN HERE Parent/Guardian:	Subscriber Name:	Subsc	riber ID:			
I give permission for Polished LLC to provide preventive care, to confirm insurance and bill my insurance for care provided. Polished LLC will make every attempt to NOT impact your regular dental checkups, by checking claims history prior to billing for any services. Contact: Ellen Gould RDH MPA email: polishedcheckin@gmail.com ; phone (508) 237-5378. SIGN HERE Parent/Guardian:	SubscriberEmployer N	lame:	Sub	scriber Date of Birth: Mor	nth Day Ye	ear
	I give permission for Polished LLC to provided. Polished LLC will make ev history prior to billing for any service	o provide preventi ery attempt to NO	T impact y	our regular dental chec	kups, by checkin	ıg claims
Data:	SIGN HERE Parent/Gua	ardian:				
T 19TA'				Dat	·o-	