



PEDIATRIC DENTISTRY  
*Healthy smiles are our specialty!*

On behalf of the whole Cape Cod Pediatric Dentistry team, we welcome you to our practice!

We know how important the health of your child is and we are grateful that you have entrusted us with their care. Our mission statements below reflect a continued commitment to our patients.

*Deliver the best dentistry possible  
Never compromise patient care  
Create a positive dental experience*

*Present our patients with all of their treatment options  
Don't assume what our patients want  
Do dentistry with our patients*

In summary, we strive to foster patient relationships based on mutual trust, excellent customer service, and the best patient care available.

- ☞ Patients of record with a dental emergency after hours can call and speak with one of our on call dentists.
- ☞ With regards to broken appointments please be advised that we ask for at least **48 hours notice** of your need to change your appointment. Should we not hear from you at least 48 hours prior to appointment, there will be a \$90 charge.
- ☞ As a **courtesy** to our patients, we will submit for services rendered, to dental insurance companies on **your** behalf. Your dental insurance status is typically updated on the day of your visit. Co-payments are calculated and collected at time of service unless alternative arrangements have been made. Our patients are responsible for informing the office of changes to their dental insurance coverage. Ultimately our patients are responsible for services not covered by their dental insurance.
- ☞ Payment is expected at time of services rendered. Acceptable methods of payment include cash, check, or credit card. Third party financing including interest free options are available.
- ☞ Return of bounced checks are subject to \$90 fee.
- ☞ During the winter months in the event of snow, please be assured that we will make every attempt to call you, should the office need to close.
- ☞ For more information visit us at [capecodpediatricdentistry.com](http://capecodpediatricdentistry.com)

Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Practice Administrator \_\_\_\_\_

Date \_\_\_\_\_

**Amy L. Fugate, DMD CAGS**

89 Lewis Bay Rd Suite 1  
Hyannis, MA 02601  
(508)-737-0816

[capecodpediatricdentistry@gmail.com](mailto:capecodpediatricdentistry@gmail.com)  
[capecodpediatricdentistry.com](http://capecodpediatricdentistry.com)



PEDIATRIC DENTISTRY  
*Healthy smiles are our specialty!*

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

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Name child would like to be called: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Names and ages of other children in the family: \_\_\_\_\_

Siblings we treat: \_\_\_\_\_

Legal Guardian 1: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Email: \_\_\_\_\_

Legal Guardian 2: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Social Security #: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Email: \_\_\_\_\_

Who has legal custody of the patient? \_\_\_\_\_

Person Responsible for payment of the account? \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

What is the reason for your child's dental visit? \_\_\_\_\_

## INSURANCE INFORMATION

Does your child have dental insurance? \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Employer: \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Relationship to Insured: \_\_\_\_\_

Insured Social Security #: \_\_\_\_\_ Insured Birthdate: \_\_\_\_\_

Insured Policy #: \_\_\_\_\_ Insured Group Number: \_\_\_\_\_

### Amy L. Fugate, DMD CAGS

89 Lewis Bay Rd Suite 1

Hyannis, MA 02601

(508)-737-0816

capecodpediatricdentistry@gmail.com

capecodpediatricdentistry.com



PEDIATRIC DENTISTRY  
*Healthy smiles are our specialty!*

### HEALTH HISTORY

- Yes  No Is your child in good health?  
Name of child's physician: \_\_\_\_\_  
Date of last physical exam: \_\_\_\_\_  
Child's weight: \_\_\_\_\_ height: \_\_\_\_\_
- Yes  No Has your child ever had a health problem? \_\_\_\_\_
- Yes  No Are your child's immunizations up-to-date? \_\_\_\_\_
- Yes  No Is your child taking any medications, vitamins, or dietary supplements? \_\_\_\_\_
- Yes  No Were there any problems at birth? \_\_\_\_\_
- Yes  No Is your child allergic to anything? \_\_\_\_\_
- Yes  No Has your child ever had surgery? \_\_\_\_\_
- Yes  No Did your child have a reaction or problem with anesthesia?
- Yes  No Is there a family history of a reaction or problem with anesthesia?
- Yes  No Has your child ever been hospitalized? \_\_\_\_\_
- Yes  No Are there any psychological or emotional problems you would like to bring to our attention?-

#### Does your child have any of the following?

- |   |  |
|---|--|
| <input type="checkbox"/> Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions | <input type="checkbox"/> Bladder or kidney problems  |
| <input type="checkbox"/> Problems with physical growth or development   | <input type="checkbox"/> Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems                |
| <input type="checkbox"/> Sinusitis, chronic adenoid/tonsil infections   | <input type="checkbox"/> Rash, hives, eczema or skin problems  |
| <input type="checkbox"/> Sleep apnea/snoring, mouth breathing, or excessive gagging   | <input type="checkbox"/> Impaired vision, hearing or speech  |
| <input type="checkbox"/> Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease           | <input type="checkbox"/> Developmental disorders, learning problems/delays, or intellectual disability                   |
| <input type="checkbox"/> Irregular heart beat or high blood pressure  | <input type="checkbox"/> Cerebral palsy, brain injury, epilepsy, or convulsions/seizures                                 |
| <input type="checkbox"/> Asthma, reactive airway disease, wheezing, or breathing problems                                     | <input type="checkbox"/> Autism/Autism spectrum disorder   |
| <input type="checkbox"/> Cystic fibrosis  | <input type="checkbox"/> Recurrent or frequent headaches/migraines, fainting, or dizziness                               |
| <input type="checkbox"/> Frequent colds or coughs or pneumonia  | <input type="checkbox"/> Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) |
| <input type="checkbox"/> Frequent exposure to tobacco smoke   | <input type="checkbox"/> Attention deficit/hyperactivity disorder (ADD/ADHD)   |
| <input type="checkbox"/> Jaundice, hepatitis, or liver problems   | <input type="checkbox"/> Behavioral, emotional, communication, or psychiatric problems/treatment                         |
| <input type="checkbox"/> Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems                   | <input type="checkbox"/> Abuse (physical, psychological, emotional, or sexual) or neglect                                |
| <input type="checkbox"/> Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions               | <input type="checkbox"/> Diabetes, hyperglycemia, or hypoglycemia  |
| <input type="checkbox"/> Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder              |  |

#### Amy L. Fugate, DMD CAGS

89 Lewis Bay Rd Suite 1  
Hyannis, MA 02601  
(508)-737-0816  
capecodpediatricdentistry@gmail.com  
capecodpediatricdentistry.com



PEDIATRIC DENTISTRY  
*Healthy smiles are our specialty!*

- |   |  |
|---|--|
| <input type="checkbox"/> Precocious puberty or hormonal problems              | <input type="checkbox"/> Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant  |
| <input type="checkbox"/> Thyroid or pituitary problems                        | <input type="checkbox"/> Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AID |
| <input type="checkbox"/> Anemia, sickle cell disease/trait, or blood disorder |  |
| <input type="checkbox"/> Hemophilia, bruising easily, or excessive bleeding   |  |
| <input type="checkbox"/> Transfusions or receiving blood products             |  |

IF YES FOR ANY OF THE ABOVE PLEASE PROVIDE DETAILS  
HERE: \_\_\_\_\_

NONE OF THE ABOVE

### DENTAL HISTORY

What is your primary concern about your child's oral health? \_\_\_\_\_

- Yes  No Has your child ever been examined or treated by another dentist?  
If YES: Date of first visit: \_\_\_\_\_ Date of last visit: \_\_\_\_\_ Reason: \_\_\_\_\_  
Were x-rays taken of the teeth or jaws?  Yes  No Date of x-rays: \_\_\_\_\_  
Has your child ever had a difficult dental appointment?  Yes  No  
If YES, describe: \_\_\_\_\_  
 Yes  No Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?

How do you expect your child will respond to dental treatment?

- Excellent  Good  Fair  Poor
- Yes  No Is there anything we should know before treating your child?  
If YES, describe: \_\_\_\_\_
- Yes  No Does your child participate in any sports or similar activities?  
 Yes  No Does your child wear a mouthguard during these activities?

Does your child have any of the following?

- |  |  |
|--|--|
| <input type="checkbox"/> Inherited dental characteristics  | <input type="checkbox"/> Mouth sores or fever blisters   |
| <input type="checkbox"/> Cavities/decayed teeth  | <input type="checkbox"/> Injury to teeth, mouth or jaws  |
| <input type="checkbox"/> Bad breath  | <input type="checkbox"/> Bleeding gums   |
| <input type="checkbox"/> Clenching/grinding teeth<br>popping, etc)   | <input type="checkbox"/> Jaw joint problems (clicking,<br><input type="checkbox"/> Excessive gagging |
| <input type="checkbox"/> Toothache   |  |
| <input type="checkbox"/> Sucking habit after one year of age   |  |
| If yes, which: <input type="checkbox"/> Finger <input type="checkbox"/> Thumb <input type="checkbox"/> Pacifier <input type="checkbox"/> Other _____ |  |
| For how long? _____  |  |

**Amy L. Fugate, DMD CAGS**

89 Lewis Bay Rd Suite 1  
Hyannis, MA 02601  
(508)-737-0816  
capecodpediatricdentistry@gmail.com  
capecodpediatricdentistry.com



PEDIATRIC DENTISTRY  
*Healthy smiles are our specialty!*

**ORAL HYGIENE AND FLUORIDE**

How would you describe:

Your child's oral health?  Excellent  Good  Fair  Poor

Your oral health?  Excellent  Good  Fair  Poor

The oral health of your other children?  Excellent  Good  Fair  Poor

Yes  No Is there a family history of cavities?

Check all that apply:  Mother  Father  Sister  Brother

How often does your child brush his/her teeth? \_\_\_\_\_ times per \_\_\_\_\_

Yes  No Does someone help your child brush?

How often does your child floss his/her teeth? \_\_\_\_\_ times per \_\_\_\_\_

Yes  No Does someone help your child floss?

What type of toothbrush does your child use? \_\_\_\_\_

What type of toothpaste does your child use? \_\_\_\_\_

What is the source of your drinking water at home?

City/community supply  Private well  Bottled water

Please check all sources of fluoride your child receives:

Drinking water  Toothpaste  Over-the-counter rinse

Prescription rinse/gel  Prescription drops/tablets/vitamins  Fluoride treatment in the dental office  Fluoride varnish by pediatrician/other practitioner

**DIET**

Yes  No Does your child regularly eat three meals each day?

Yes  No Is your child on a special or restricted diet?

Yes  No Is your child a 'picky' eater?

Yes  No Does your child have a diet high in sugar or starches?

Yes  No Do you have concerns regarding your child's weight?

How frequently does your child have the following?

Candy or other sweets  Rarely  1-2 times/day  3 or more times/day

Product \_\_\_\_\_

Chewing gum  Rarely  1-2 times/day  3 or more times/day

Type \_\_\_\_\_

Snacks between meals  Rarely  1-2 times/day  3 or more times/day

Usual snacks \_\_\_\_\_

**Amy L. Fugate, DMD CAGS**

89 Lewis Bay Rd Suite 1  
Hyannis, MA 02601  
(508)-737-0816

capecodpediatricdentistry@gmail.com  
capecodpediatricdentistry.com



PEDIATRIC DENTISTRY  
Healthy smiles are our specialty!

Soft drinks\*  Rarely  1-2 times/day  3 or more times/day

Product \_\_\_\_\_

(\*this includes juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: \_\_\_\_\_

**SUPPLEMENTAL QUESTIONS IF YOUR CHILD IS AN INFANT/TODDLER**

Yes  No Was your child born prematurely?  
If YES, what week? \_\_\_\_\_

What was your child's birth weight? \_\_\_\_\_

How long was your child breast-fed?

N/A  Less than 6 months  6-11 months  12-17 months  18-23 months  2 years or more

How long was your child bottle-fed?

N/A  Less than 6 months  6-11 months  12-17 months  18-23 months  2 years or more

Yes  No Did/do you feed your child infant formula?

Yes  No Does/did your child sleep with a bottle?

Yes  No Does/did your child use a no-spill training cup (sippy cup)?

Child's age (in months) when first tooth appeared in mouth \_\_\_\_\_

Yes  No Has your child experienced any teething problems?

When did you begin brushing your child's teeth?

N/A  Less than 6 months  6-11 months  12-17 months  18-23 months  2 years or more

When did you begin using toothpaste?

N/A  Less than 6 months  6-11 months  12-17 months  18-23 months  2 years or more

Signature of parent/guardian: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Signature of staff member reviewing history: \_\_\_\_\_ Date: \_\_\_\_\_

**Amy L. Fugate, DMD CAGS**

89 Lewis Bay Rd Suite 1  
Hyannis, MA 02601  
(508)-737-0816

capecodpediatricdentistry@gmail.com  
capecodpediatricdentistry.com



PEDIATRIC DENTISTRY

*Healthy smiles are our specialty!*

### **Financial and Appointment Policy**

Thank you for choosing Cape Cod Pediatric Dentistry for your child's dental home! We are committed to their successful treatment and prevention! Please understand that payment of your bill is considered a part of your child's treatment.

Please be aware that the parent bringing the child to Cape Cod Pediatric Dentistry is legally responsible for payment of all charges. We cannot send statements to other persons.

**Co-Payments and Deductibles** are to be paid at each appointment as services are rendered. For your convenience we accept cash, personal checks, Visa, and MasterCard. Please know our office does not accept post-dated checks. There will be a **\$90 fee** for any returned checks.

**Dental Insurance** – We strongly urge you to thoroughly review your insurance plan guidelines/booklet prior to the appointment. There is NO direct relationship between our office and your insurance company. The type of plan chosen by you, and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms in the contract, the methods of reimbursement or the determination of your insurance benefits. As a courtesy to our patients if we have received all of your insurance information on the day of the appointment, we will electronically file your dental insurance claims and bill your dental insurance company for treatment you receive when this is possible. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you. Balances unpaid by your insurance company will be billed to you and must be paid within **thirty (30) days**.

**Emergency Treatment** – All emergency treatment must be paid in full at the time the service is rendered. There is an additional fee not covered by insurance for after hours and/or holiday treatments that is also due at the time of service.

**Hospital Appointments** – A **five-hundred fifty (\$550) dollar deposit** is required to book an appointment for your child at one of the hospitals Dr. Fugate has privileges at. This deposit will be put towards the patient financial responsibility of the surgery booked. You must give **two (2) weeks' notice** to change the date of your surgery, as it is an extensive process to book your child. If you do not give two (2) weeks' notice and/or you do not present for your appointed surgery your deposit will be forfeited to the practice and Cape Cod Pediatric Dentistry reserves the right to dismiss the patient from the practice. We thank you in advance for understanding this policy.

**Appointments** – If your child is under the age of 9 years old we ask that you schedule a morning appointment. Younger children do better when they are well rested. We pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. We require you to provide us with at least 48 hours' notice if you need to reschedule your appointment. If this notice is not given a fee will be incurred and if it happens twice (2 times) Cape Cod Pediatric Dentistry will assist you in finding a dental home that accommodates your schedule better. If no notice is given, the patient is considered a "no show" and Cape Cod Pediatric Dentistry reserves the right to dismiss the patient.

We strive to provide our patients with the best possible care. Therefore, late arrivals cause schedule delays for patients who arrive promptly to their appointment. Late arrivals will be worked into the schedule if time allows or re-appointed to another day. With more than two (2) late arrivals Cape Cod Pediatric Dentistry will assist you in finding a dental home that has hours that accommodates your schedule better. During the school months, late afternoon appointments are in high demand. We try to honor after school requests and ask that you help us by understanding when we need to appoint during school hours. We will gladly provide you with a school excuse for your child.

We understand that under unusual circumstances an account balance may be incurred. Cape Cod Pediatric Dentistry requires that all outstanding balances be paid in full within **thirty (30) days** unless other arrangements have been made. Also note, if we have not received payment or you have not contacted us in thirty (30) days, further action may be taken with a collection agency or with Small Claims Court. You will be responsible for any fees incurred including court costs and attorney fees. There will be a twenty five percent (25%) finance charge added to the account for each month the account is overdue after 30 days. Thank you in advance for your understanding of our financial policy.

I have read Cape Cod Pediatric Dentistry's Financial and Appointment Policy and agree to abide by its contents.

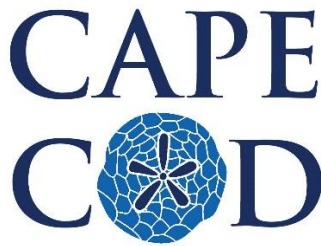
Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Amy L. Fugate, DMD CAGS**

89 Lewis Bay Rd Suite 1  
Hyannis, MA 02601

(508)-737-0816

capecodpediatricdentistry@gmail.com  
capecodpediatricdentistry.com



PEDIATRIC DENTISTRY  
*Healthy smiles are our specialty!*

### Pediatric Dentistry Informed Consent

- Dental Treatment;** I understand that I may have any of the following treatment done which include but are not limited to: exams, cleanings (deep and regular), fluoride, radiographs (X-Rays), sealants, silver and white dental restorations, nerve treatments, extractions, and space maintainers. It is MA Board requirement we take radiographs (x-rays) per the current ADA Guidelines based on risk. Any family unwilling to abide by these guidelines, we will assist in finding a new dental home. We are unable to treat families that do not comply with standard of care guidelines. This also includes vaccinations performed by the Primary Care Physician.
- Medications and Prescriptions;** 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. In very rare instances, local anesthesia ("Novocain") can cause paresthesia (discomfort in the nerves of the mouth, teeth or jaw) or even permanent anesthesia.
- Changes in Treatment Plan;** I understand that during treatment it may be necessary to change or add procedures because of conditions found while treating the teeth which were not discovered during the examination, i.e. root canal therapy or extraction following routine restorative procedures. I give my permission to the dentist to make any and all changes and additions for the best of my child's care.
- Dental Insurance;** I understand that it is **my responsibility** to have the correct dental insurance information. I understand that I need to inform Cape Cod Pediatric Dentistry of any changes to my insurance. I understand that Cape Cod Pediatric Dentistry will submit claims as a courtesy to me.
- General;** I understand dentistry is not an exact science and that therefore, reputable practitioners cannot properly guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment, which I have requested and authorized. I hereby authorize the doctors at Cape Cod Pediatric Dentistry and the dental auxiliaries to proceed and perform the dental restorations and treatments as explained to me. I understand that this is only an estimate and subject to modification depending on the unforeseen or un-diagnosable circumstances that may arise during the course of treatment.

\*I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation.

\*I understand that this agreement is to verify that I wish to be treated by Cape Cod Pediatric Dentistry, Inc.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Print Guardian's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Amy L. Fugate, DMD CAGS**

89 Lewis Bay Rd Suite 1

Hyannis, MA 02601

(508)-737-0816

capecodpediatricdentistry@gmail.com

capecodpediatricdentistry.com

# CAPE COD

PEDIATRIC DENTISTRY  
*Healthy smiles are our specialty!*

I, \_\_\_\_\_ give Cape Cod Pediatric Dentistry, Inc.  
permission to use my cell phone number to:

- Call
- Text

Phone Number: \_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_

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

Date: \_\_\_\_\_

**Amy L. Fugate, DMD CAGS**  
89 Lewis Bay Rd Suite 1  
Hyannis, MA 02601  
(508)-737-0816  
capecodpediatricdentistry@gmail.com  
capecodpediatricdentistry.com