Pediatric Dental Care

10614 Warwick Avenue Suite B **Fairfax, VA 22030**

703-383-3434

Patient Information

Patient Name: ____ Date: __________

Last, First MI (Preferred Name)

Nickname: ______________________ Gender: __________ Family Status: ____________

Social Security #: __________________________ Birth Date: ________________________

Phone (Home): ____________ (Work): ____________ Ext: _______ Best time to call: __________

Address: ____

Street Apartment #

____

City State Zip Code

First Names of Child's Siblings: ______________________ Child's School: ____________________ Grade: _____

Health Information

Date of Last Dental Visit: ______________ Reason for this visit: __________________________

Has your child ever had any of the following? (These questions help us to treat and better understand your child.) **Please check those that apply:**

- ☐ AIDS / HIV+
- ☐ Allergies ____________ ____________
- ☐ Anemia
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Cleft Lip/Palate
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear Aches
- ☐ Emotional Problems
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Frequent Headaches
- ☐ Handicap / Disabilities
- ☐ Has Taken Phen / Fen
- ☐ Head Injuries
- ☐ Hearing Impaired
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Learning Disabilities (A.D.D. Dyslexia, Hyperactivity)
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sore Throat
- ☐ Speech Problems
- ☐ Stomach Problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Up to Date on Immunizations
- ☐ Codeine Allergy
- ☐ Latex Allergy
- ☐ Penicillin Allergy

OTHER:
- ☐ ________________
- ☐ ________________

- Is your child's water fluoridated? ☐ Yes ☐ No
- Is your child taking any fluoride supplements? ☐ Yes ☐ No
- Has your child ever had any jaw pain or tenderness? ☐ Yes ☐ No
- Does your child brush their teeth daily? ☐ Yes ☐ No
- Does your child floss their teeth daily? ☐ Yes ☐ No

Does your child have any of the following habits?

Thumb / Finger sucking / Pacifier ☐ Yes ☐ No

Nail biting ☐ Yes ☐ No

Mouth breathing ☐ Yes ☐ No

Nursing bottle habits / Breast-feeding ☐ Yes ☐ No

- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ____
- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ____
- Is your child now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ____
- Name of Physician: ______________________________ Phone: ____________
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child's health changes, I will inform the doctors at the next appointment without fail.

____ Date: ______________

Signature of parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ______________________________

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

Acct#:________________

Responsible Party Information

The following is for: ☐ the patient's mother ☐ the patient's father ☐ the patient's guardian

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ____________

Social Security #: ______________________ Birth Date: ______________________

Phone (Home): ____________ (Work): ____________ Ext: ____ Best time to call: __________

Address: ____

Street Apartment #

____

City State Zip Code

Employment Information

The following is for: ☐ the patient's mother ☐ the patient's father ☐ the patient's guardian

Employer Name: ______________________ Occupation: ______________________

Address: ____

Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ____

Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ____

Last First MI

Insured's Birth Date: ____________ ID #: ____________ Group #: ____________

Insured's Address: ____

Street City State Zip Code

Insured's Employer Name: ____

Address: ____

Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

____

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 and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or 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.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

A $25 fee will be charged for each check returned by the bank.

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 his 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 parent or guardian

______________________________ Date: __________ Relationship to Patient: ______________

Signature of guarantor of payment/responsible party

Acct#:______________________