Falls Church Pediatric Dental Center

WELCOME KIDS!

We would like to welcome your child to our office.
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.

Tell Us About Your Child

Today's Date: _____
Child's Name: _____
Last First Middle
Child's Birthdate: ___/___/___ Child's Age: _____
Nickname: _____ ❑ Male ❑ Female
School: _____ Grade: _____
Hobbies: _____
Child's Home #: ( ) _____
Social Security #: _____
Child's Home Address: _____
#Apt. / Condo
_____
City State Zip Code

General Information

Who is accompanying the child today? _____
Relation: _____
Who has legal custody of the child? _____
Relation: _____
Who may we thank for referring you? _____
Other siblings: _____
Previous/ Present Dentist: _____ Last visit date: _____
Dentist Phone # : ( ) _____
Date of Adoption, if applicable: _____
What is the parent's primary language? _____
What is the child's primary language?: _____

Parent's Information

Person responsible for Account: _____ Parent's Marital Status: ❑ Married ❑ Single ❑ Partnered ❑ Divorced ❑ Separated

❑ **Father** ❑ Step Father ❑ Guardian
Name: _____ Birthdate: ___/___/___
Address: (if different than Child's): Hm#: ( ) _____
_____
City: _____ State: _____ Zip Code: _____
SS #: _____ DL#: _____
Wk #: ( ) _____ Ext: _____ Cell/other #: ( ) _____
Email: _____
Employer _____
Employer's Address: _____
City State Zip Code
If you have Dental Insurance Coverage for the Child, please fill out below:
Policy Holder's Name: _____
Insurance Co. Name: _____
Insurance Address: _____
City State Zip Code
Insurance Phone #: ( ) _____
Group # (Plan, Local or Policy #): _____

❑ **Mother** ❑ Step Mother ❑ Guardian
Name: _____ Birthdate: ___/___/___
Address: (if different than Child's): Hm#: ( ) _____
_____
City: _____ State: _____ Zip Code: _____
SS #: _____ DL#: _____
Wk #: ( ) _____ Ext: _____ Cell/other #: ( ) _____
E-mail: _____
Employer: _____
Employer's Address: _____
City State Zip Code
If you have Dental Insurance Coverage for the Child, please fill out below:
Policy Holder's Name: _____
Insurance Co. Name: _____
Insurance Address: _____
City State Zip Code
Insurance Phone #: ( ) _____
Group # (Plan, Local or Policy #): _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____
Signature of Parent or Guardian Date

Dental History

Why did you bring the child to see the dentist today? _____

Is the child currently in pain? ❑Yes ❑ No

Does the child require antibiotics before dental treatment? ❑Yes ❑ No

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

Is the child's water fluoridated? ❑Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ❑Yes ❑No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Does the child floss his/her teeth daily? ❑Yes ❑ No

Is the child currently under the care of a physician? ❑Yes ❑No

Child's Physician: _____

Phone #: ( ) _____

Date of Last Visit: _____

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list any drugs that the child is currently taking: _____

Please list all drugs that the child is allergic to:

Y N Allergic to Latex
Y N Allergic to Nickel
Y N Allergic to Metals
Y N Allergic to Plastic

Medical History

Has the child experienced any of the following medical problems?

Y N Abnormal Bleeding/ Hemophilia
Y N ADD/ADHD
Y N AIDS/HIV+
Y N Anemia
Y N Any Hospital Stays/Operations?
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Handicaps/Disabilities
Y N Hearing impairment
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are the child's immunizations current? ❑Yes ❑ No

Is there anything you would like to discuss with the Doctor in Private? ❑Yes ❑ No

Please discuss any serious medical problems the child experiences/ed:

Does/did the child experience any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N SpeechProblems
Y N Thumb/finger Sucking
Y N Tongue/Cheek Sucking
Y N Tongue Thrust
Y N Used Pacifier

Our office is HIPPA compliant and is committed to meeting or exceeding the standards of infection control made by OSHA

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform his office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____ Date _____

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Signature of Dentist _____ Date _____

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? ❑Yes ❑ No

If Yes, Please explain: _____

Has there been any change in your child's health status since their last visit? ❑Yes ❑ No

If Yes, Please explain: _____

Parent /Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Parent /Guardian Signature _____ Date _____

Dentist Signature _____ Date _____