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DIPLOMATES OF THE AMERICAN BOARD OF PEDIATRIC DENTISTRY
Dentistry for Children, Adolescents & Special Needs
703-978-0051 KDPediatricSmiles.com
SUITE F · 5631 BURKE CENTRE PARKWAY · BURKE, VA 22015

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's name _____Nickname_____Age_____

Sex_____ Date of Birth _____School _____Grade_____

Patient's Interests and Hobbies_____

Father's Name _____Mother's Name_____

Home Address _____Home phone: _____

Father's Occupation _____Work Phone _____Cell Phone _____Email_____

Mother's Occupation _____Work Phone _____Cell Phone _____Email_____

Name and Ages of Other Children in Family _____

Person Responsible For Payment of Account _____SS #_____Driver's License #_____

Do you have a Dental Insurance Plan? Yes _____ No _____

Insured's Name _____ Name of Plan _____ Policy #_____

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Signature_____ Date _____

Whom may we thank for referring you? _____

MEDICAL HISTORY YES NO

Child's Physician _____ Phone_____

Is your child in good health? ..... ___ ___

Does your child have regular medical examinations? ..... ___ ___

Has your child any history of problems with: (X) any applicable—

( ) Heart Condition or Murmur	( ) Asthma	( ) Allergies	( ) Kidney, Liver, or GI	( ) ADD	( ) Cancer
( ) Tuberculosis	( ) Lung	( ) Diabetes	( ) Epilepsy	( ) ADHD	( ) AIDS
( ) Bleeding Disorders	( ) Rheumatic Fever	( ) Hepatitis	( ) Sickle Cell Anemia	( ) Autism	( ) Other

Has your child any difficulties with hearing, speech, vision? Explain ..... ___ ___

Has your child a cerebral or spastic condition? Explain ..... ___ ___

Has your child any emotional, mental, or nervous disorders? Explain ..... ___ ___

Is your child presently taking any medications? Please List: ..... ___ ___

Is your child allergic to any medications or latex? Please List: ..... ___ ___

Is your child presently undergoing medical treatment? ..... ___ ___

Has your child ever been hospitalized since birth? ..... ___ ___

If so, Date: _____ Reason: _____

TURN OVER

DENTAL HISTORY YES NO

Is this your child's first visit to the dentist? ..... ___ ___

When did your child last receive dental care? Date _____Previous Dentist: _____Phone #:_____

Reason for this visit. _____

Was your child bottle fed or breast fed? To what age? _____.....___ ___

Does your child have any oral habits such as thumb sucking or nail biting?.....___ ___

If yes, please explain _____

Do you have "well" water? .....___ ___

Is your child taking fluoride in any form? .....___ ___

Has there been any injury to the mouth or teeth? When _____ Describe_____ ___ ___

_____

Has your child ever had a toothache? When _____Describe _____ ___ ___

_____

Is there any other information concerning your child's health which should be known?_____

_____

● We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider, patient's parents, and patient.

● Our policy requires payment in full for all services rendered at the time of the visit, unless other arrangements have been made with the office. If account in not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges, and any other expenses incurred in collecting your account.

● I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date _____

Relationship _____