



Welcome to Ashburn Pediatric Dental Center!!

Today's Date: _____

Patients Full Name: _____
LAST FIRST M.I.

Patients Nickname: _____ Date of Birth: _____ M F

Child's School: _____ Grade: _____

Child's Home Phone: _____ Social Security #: _____

Child's Home Address: _____
Street City State Zip

How did you hear about our office? _____

Reason For today's visit: Exam Emergency Consultation

Child's previous dentist: _____

Last Dental Exam ___/___/___ Last Dental X-rays: ___/___/___

Is the child in pain: No Yes How long: _____

Any other Dental Concerns? _____

Does your child have or ever had any of the following medical conditions?

Y N Heart Murmur	Y N Tonsillitis	Y N High/low blood pressure
Y N Rheumatic fever	Y N Respiratory problems	Y N Hepatitis
Y N Artificial Heart Valves	Y N Asthma	Y N Artificial Bones/Joints
Y N Congenital Heart defect	Y N Blood Transfusion	Y N Organ Problems
Y N Scarlet Fever	Y N Leukemia/Anemia	Y N HIV/AIDS/ARC
Y N Surgeries/Operations	Y N Diabetes/hypoglycemia	Y N Tuberculosis TB
Y N Cancer/Tumors	Y N Hemophilia	Y N Psychiatric Problems/Autism
Y N Chemotherapy	Y N Abnormal bleeding	Y N Hyperactive ADD
Y N Jaw problem TMJ/TMD	Y N Cleft lip/palate	Y N Fainting/seizures/epilepsy
Y N Hearing problem	Y N Birth defects	Y N Cerebral Palsy

Please list any other medical condition(s) _____

Does child require pre-medication? Yes No Don't know

Is Child taking any of the following medications? Pain Killers (including ASPIRIN)

Ritalin Stimulants Blood Thinners Tranquilizers Insulin Muscle relaxers

Others: _____

Any allergies to: Latex Penicillin/Amoxicillin Tetracycline Novocaine

Aspirin Food allergies Others: _____

Has this Child ever taken the drug Ritalin? No Yes/How long? _____

Who is accompanying this child today?

PLEASE INCLUDE AT LEAST 2 CONTACT NUMBERS

Do have legal Custody of this child? Yes No

Mother's Name: _____

Guardian

Mother's Home Address: _____
(CHECK IF SAME AS CHILD'S) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Email address: _____

Mother's Social Security Number _____ - _____ - _____ Date of Birth ____/____/____

Mother's Employer: _____ Occupation: _____

Father's Name: _____

Guardian

Father's Home Address: _____
(CHECK IF SAME AS CHILD'S) Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Email address: _____

Father's Social Security Number _____ - _____ - _____ Date of Birth ____/____/____

Father's Employer: _____ Occupation: _____

Primary Dental Insurance

Policy Holder's Full Name: _____

Policy Holder's SSN#: _____

ID # on the card: _____

Date of Birth: ____/____/____

Name of Employer: _____

Group Number: _____

Relation to patient: _____

Name of Insurance Company and address: _____

_____ Street City State Zip

Insurance Company Phone:(_____)_____-_____

Secondary Dental Insurance

Policy Holder's Full Name: _____

Policy Holder's SSN#: _____

ID # on the card: _____

Date of Birth: ____/____/____

Name of Employer: _____

Group Number: _____

Relation to patient: _____

Name of Insurance Company and address: _____

_____ Street City State Zip

Insurance Company Phone:(_____)_____-_____

Person ultimately responsible for account

Name: _____
Relation to child

Billing Address: _____
(CHECK IF SAME AS ABOVE) Street City State Zip

Initials 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 (if offered at this office).

- ❖ 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 and patient.
- ❖ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager prior to treatment. If account is not paid within 60 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in the collecting your account.
- ❖ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- ❖ 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: _____
 Parent or Guardian Other: