nova Children's Dentistry of ASHBURN
"smiles for a lifetime"

Date: _____

Patient Information

Child's Full Name: _____ Name called by: _____

Age: _____ Date of Birth: ___/___/___ Sex: ❑ M ❑ F Place of Birth: _____

Child's Home Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone: (___) _____

Brothers (Names & Ages): _____

Sisters (Names & Ages): _____

Child's Physician: _____ Phone: (___) _____

Address: _____ Date of Last Exam: _____

Whom may we thank for referring your child to our office? _____

Parent/Guardian Information

Parent/Guardian Name: _____

Relationship to Patient: _____ Email Address: _____

Social Security Number: ___/___/___ Date of Birth: _____

Employer: _____ Cell Phone: (___) _____

Home Address (if different from above): _____

Parent/Guardian Name: _____

Relationship to Patient: _____ Email Address: _____

Social Security Number: ___/___/___ Date of Birth: _____

Employer: _____ Cell Phone: (___) _____

Home Address (if different from above): _____

Emergency Contact/Friend or Relative Not Living With You

Name: _____ Phone: (___) _____

Address: _____ Relationship to Patient: _____

Insurance Information

Insured's Name: _____ Relationship to Patient: _____

Insured's Date of Birth: _____ Insured's SSN /ID#: _____

Insured's Employer: _____

Name of Insurance Company: _____ Group Number: _____

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 NOVA Children's Dentistry of Ashburn of any changes to the information I have provided. I agree to be responsible for all charges for dental services and materials not paid by my dental plan benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted by law, I authorize release of any information relating to claims filed.

_____ _____

Signature of Insured Date

I hereby authorize payment of the dental benefits otherwise payable to me directly to NOVA Children's Dentistry of Ashburn.

_____ _____

Signature of Insured Date

Please Continue on Next Page

Child's Name: _____

Child's Medical History

Please list any medications your child is currently taking: _____

Does your child have, or has he/she ever had, any of the following diseases, conditions or procedures?

- ☐ Cancer/Tumors
- ☐ Chemotherapy
- ☐ HIV + AIDS / ARC
- ☐ Abnormal Bleeding
- ☐ Anemia / Blood Disorders
- ☐ Bruises Easily
- ☐ Diabetes / Blood Sugar Problems
- ☐ Blood Transfusions
- ☐ High / Low Blood Pressure
- ☐ Tonsillitis
- ☐ Birth Defects
- ☐ Cleft Lip / Palate
- ☐ Autism Spectrum
- ☐ Speech, Learning, or Hearing Disabilities
- ☐ Developmental Delays
- ☐ Psychological or Emotional Problems
- ☐ Glandular or Hormonal Problems
- ☐ ADHD / ADD
- ☐ Kidney Bladder Problems
- ☐ Liver Problems, Jaundice or Hepatitis
- ☐ Convulsions, Seizures, Fainting or Epilepsy
- ☐ Rheumatic Fever / Rheumatic Heart Disease
- ☐ Congenital Heart Disease or Heart Murmur
- ☐ Arthritis or Rheumatism
- ☐ Tuberculosis or Pneumonia
- ☐ Jaw Problems: TMJ / TMD
- ☐ Asthma or Hay Fever
- ☐ Accidents or Severe Infections
- ☐ Any Recent or Pending Surgery/Recent Injuries
- ☐ Sensory Processing Disorder

If **yes** to any of the above please explain: _____

Are your child's immunizations current? ☐ Yes ☐ No If **no** please explain: _____

Name of Pharmacy: _____ Phone: ( ) _____

Is your child allergic to: ☐ Latex ☐ Penicillin / Amoxicillin ☐ Tetracycline ☐ Red Dyes ☐ Aspirin
☐ Sulfa Drugs ☐ Dental Anesthetics ☐ Other(s): _____

Does your child have any of the following mouth habits? ☐ Thumb Sucking ☐ Mouth Breathing
☐ Pacifier ☐ Nail Biting ☐ Finger Sucking ☐ Grinding/Clenching ☐ Other(s): _____

Dental History

Date of last dental visit: _____ By Dr. _____

Do you have any records (including x-rays) from another practice? _____

Has your child ever complained about any dental problems? _____

Does your child still take a bottle or sippy cup? _____

Does your child brush daily? ☐ Yes ☐ No How often? _____

Do you assist your child with brushing? ☐ Yes ☐ No How often? _____

Is dental floss used? _____

How does your child receive Fluoride?

☐ Water Supply ☐ Dentist ☐ Toothpaste ☐ Vitamins ☐ Tablets ☐ None ☐ Other: _____

Child's attitude towards Dentistry: _____

Reason for Today's Visit/Chief Concerns: _____

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 of Insured Date

_____
Print Name

Print Form

This Space For Internal Use

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