# *Welcome to Central Virginia Family Dentistry*

**Today's Date**____/____/____

Child's Name_____
Last First MI

Nickname_____ ☐Male ☐Female

Birthdate____/____/____ Age_____ SS#_____

Mailing Address_____
Street City State Zip

Home #_____ Email for Notifications_____

Referred By (if a doctor, please list phone #)_____

Accompanying child today_____ Relationship_____

Do you have legal custody of this child? ☐**Yes** ☐**No**

**Mother's Name**_____ ☐Step Mother ☐Guardian

Birth Date____/____/____ Social Security #_____ Driver's License #_____

Address (☐ **Check if same as child's**)_____
Street City State Zip

Home#_____ Cell #_____ Work #_____

**Father's Name**_____ ☐Step Father ☐Guardian

Birth Date____/____/____ Social Security #_____ Driver's License #_____

Address (☐ **Check if same as child's**)_____
Street City State Zip

Home#_____ Cell #_____ Work #_____

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**Primary Dental Insurance Company**_____

Subscriber's Name_____ Date of Birth____/____/____

Relationship to Patient_____ Subscriber's Employer_____

Ins. Address_____ Phone#_____
City State Zip

Member ID #_____ Group #_____

**Secondary Dental Insurance Company**_____

Subscriber's Name_____ Date of Birth____/____/____

Relationship to Patient_____ Subscriber's Employer_____

Ins. Address_____ Phone # _____
City State Zip

Member ID #_____ Group #_____

## Dental Information

Reason for visit: ☐Exam ☐Emergency ☐Consultation Is child in pain: ☐No ☐Yes How long?_____

Previous Dentist_____ Phone#_____

Last Exam_____/_____/_____ Last X-rays_____/_____/_____

Times a day child brushes_____ Times a day child flosses_____ Is child's water fluoridated?☐ Yes ☐No ☐Unsure

**Does child tolerate water in their face? ☐Yes ☐No Will child sit alone in chair for procedure? ☐Yes ☐No ☐Unsure**

## Indicate the following problems

☐Discomfort, clicking, popping, or locking jaw ☐Lost/broken filling(s) ☐Stained teeth ☐Teeth grinding

☐Red, swollen, or bleeding gums ☐Sensitive tooth, teeth, or gums ☐Bad breath ☐Ringing in ears

☐Broken/chipped tooth ☐Blister/sores in or around mouth ☐Other_____

## Medical Information

Is child allergic to: ☐Latex ☐Penicillin/Amoxicillin ☐Tetracycline ☐Aspirin ☐Dental Anesthetics

☐ Food_____ ☐Other:_____

**Does child require antibiotic pre-medication ☐Yes ☐No ☐Unsure**

**Child's Primary Care Physician**_____

**Phone**_____ **Date of last medical exam** _____/_____/_____

## Current medications ☐Ritalin ☐Pain killers ☐ Aspirin ☐Muscle Relaxers ☐Stimulants ☐Blood Thinners

☐Tranquilizers ☐Insulin ☐Others, please list_____

## PLEASE DO NOT LEAVE UNMARKED - Please check Yes or No

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| ☐Yes ☐No | Alcohol Abuse | ☐Yes ☐No | Heart Attack | ☐Yes ☐No | Stroke |
| ☐Yes ☐No | Allergies | ☐Yes ☐No | Heart Murmur | ☐Yes ☐No | Taken Phen-fen/Redux |
| ☐Yes ☐No | Anemia | ☐Yes ☐No | Heart Surgery | ☐Yes ☐No | Taking Blood Thinners |
| ☐Yes ☐No | Arthritis | ☐Yes ☐No | Hepatitis A | ☐Yes ☐No | Thyroid Problems |
| ☐Yes ☐No | Artificial Heart Valves | ☐Yes ☐No | Hepatitis B | ☐Yes ☐No | Tuberculosis |
| ☐Yes ☐No | Artificial Joint | ☐Yes ☐No | High Blood Pressure | ☐Yes ☐No | Stomach Ulcers/Problems |
| ☐Yes ☐No | Asthma | ☐Yes ☐No | Jaw Problems | ☐Yes ☐No | Venereal Disease |
| ☐Yes ☐No | Bleeding Problems | ☐Yes ☐No | Kidney Problem | ☐Yes ☐No | Hearing Problems |
| ☐Yes ☐No | Chemo/Cancer _____ | ☐Yes ☐No | Knee Replacement | ☐Yes ☐No | Scarlet Fever |
| ☐Yes ☐No | Chest Pains | ☐Yes ☐No | Liver Disease | ☐Yes ☐No | Respiratory Problems |
| ☐Yes ☐No | Congenital Heart Defect | ☐Yes ☐No | Low Blood Pressure | ☐Yes ☐No | Hepatitis C |
| ☐Yes ☐No | Diabetes | ☐Yes ☐No | Mitral Valve Prolapse | ☐Yes ☐No | Tonsillitis |
| ☐Yes ☐No | Difficulty Breathing | ☐Yes ☐No | Nervousness | ☐Yes ☐No | Cleft Lip/Palate |
| ☐Yes ☐No | Drug Abuse | ☐Yes ☐No | Pace Maker | ☐Yes ☐No | Blood Transfusion |
| ☐Yes ☐No | Epilepsy | ☐Yes ☐No | Pre-medication | ☐Yes ☐No | Hemophilia |
| ☐Yes ☐No | Fainting | ☐Yes ☐No | Psychiatric History | ☐Yes ☐No | Hypoglycemia |
| ☐Yes ☐No | Fever Blisters | ☐Yes ☐No | Rheumatic Fever | ☐Yes ☐No | Leukemia |
| ☐Yes ☐No | Head Aches | ☐Yes ☐No | Seizures | ☐Yes ☐No | Bone Cancer |
| ☐Yes ☐No | Glaucoma | ☐Yes ☐No | Shingles | ☐Yes ☐No | Birth Defects |
| ☐Yes ☐No | HIV/AIDS | ☐Yes ☐No | Sickle Cell | ☐Yes ☐No | Hyper Active/ADD |
| ☐Yes ☐No | Hay Fever | ☐Yes ☐No | Sinus Problems | ☐Yes ☐No | Cerebral Palsy |

Please list any surgeries or medical conditions: _____

_____

Has this child ever taken the drug Ritalin? ☐No ☐Yes/How long?_____ Child's blood type_____

Does this child do any of the following? ☐Thumb/Finger Sucking ☐Tongue Thrusting/Sucking

☐Heavy Snoring ☐Mouth Breathing ☐Lip Sucking/Biting

❖I understand the above information and guarantee this form was completed 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_____

☐Adult Patient ☐Parent/Guardian ☐Spouse