Child's Name:____________________________ Nickname:_________ Age:_____ Date of Birth:__________ Sex: M / F
Permanent Addresss:________________________________________________________________________________
City:___________________________ State:______ Zipcode:________________ Phone:________________________

| Mother's Information | | Father's Information |
|---|---|---|
| ____________________________ | Name | ____________________________ |
| ____________________________ | Date of Birth | ____________________________ |
| ____________________________ | Employer | ____________________________ |
| ____________________________ | Home Phone | ____________________________ |
| ____________________________ | Work Phone | ____________________________ |
| ____________________________ | Cell Phone | ____________________________ |
| ____________________________ | Social Security Number | ____________________________ |

List names of brothers and sisters__________________________________________________________________
Medical Insurance Company:________________________ Medical Policy #:______________________________
Dental Insurance Company:____________________________ Dental Policy #________________________
Dental Group #___________________ Phone:__________________________
Name of Insured:_____________________________ DOB:___________ Social Security Number:_________________
Whom may we thank for referring your child to us? _______________________________________________________
What is your child's favorite: school subject _______________ sport____________ hobby_____________

## Medical History

Does your child have any history of the following **medical conditions**? *(please check all that apply)*

- ☐ Abuse (physical/sexual)
- ☐ Anemia
- ☐ Asthma/Reactive airway disease
- ☐ ADD/ADHD
- ☐ Autism/Asperger's/PDD
- ☐ Bladder problems
- ☐ Bleeding disorders (prolonged)
- ☐ Blood transfusions
- ☐ Brain injury
- ☐ Cancer: Type_______________
- ☐ Cerebral Palsy
- ☐ Cleft lip/palate
- ☐ Developmental delay
- ☐ Diabetes
- ☐ Emotional/psychiatric disability
- ☐ Endocrine disturbance
- ☐ Eye problems
- ☐ Fainting/frequent headaches
- ☐ Gastrointestinal/reflux problems
- ☐ Hearing problems
- ☐ Heart problems/murmurs Type______
- ☐ Hepatitis/liver disease
- ☐ HIV infection (AIDS)
- ☐ Kidney problems
- ☐ Learning disability
- ☐
- ☐ Neurological disorders/shunts
- ☐ Orthopedic problems
- ☐ Pregnancy
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Seizure disorder Type__________
- ☐ Sickle Cell Disease/Trait
- ☐ Snoring
- ☐ Speech problems
- ☐ Spina Bifida
- ☐ Syndrome Type______________
- ☐ Tuberculosis
- ☐ Other comments_______________

Is your child CURRENTLY taking any **medications**? ___No___Yes

| Drug | Dosage and Frequency | Reason |
|---|---|---|
| | | |
| | | |
| | | |

Has your child ever had an **allergic** reaction to:

| | | |
|---|---|---|
| Antibiotics/medications | ___ No ___ Yes __________________ | |
| Latex | ___ No ___ Yes __________________ | |
| Dental anesthetics | ___ No ___ Yes__________________ | |
| Food | ___ No ___ Yes__________________ | |
| Other | ___ No ___ Yes__________________ | |

Child's Physician/Pediatrician:_______________________________Phone:_______________________

Address:___________________City:____________State:_________Zip:_________

Date of last physical exam: ___________________Are you child's immunizations current? ___No ___Yes

How is your child's general health?__________________________Height:___________Weight:__________

Were there any complications during pregnancy/delivery? ___No ___Yes______________________________

Has your child had any serious illness? ___No ___Yes, explain_______________________________________

Has your child ever been hospitalized? ___No ___Yes, where, when, why?____________________________

Has your child ever undergone surgery? ___No ___Yes, where, when, why?____________________________

If yes, was general anesthesia used? ___No ___Yes, were there any complications? __ No ___Yes__________

Has your child ever been told that they need antibiotics before dental treatment? ___No ___Yes

Are there any dental or medical health problems that you would like to talk about privately with the dentist? NO YES

# Dental History

What brings you here today?______________________________________________________________

Date of last dental visit____________________________Reason for last visit_____________________________

Name of previous dentist______________________________ Were x-rays taken?__________________________

How do you think your child will do today?___________________________________________________

| | Yes | No |
|---|---|---|
| Has your child complained about dental problems? ___________________________ | | |
| Are there any dental problems concerning you at this time?______________________ | | |
| Any injuries to mouth/teeth/head?________ ________________________________ | | |
| Any oral habits? thumbsucking, finger sucking, bottle, pacifier, tongue thrust, nail biting (circle) | | |
| Any unhappy dental experiences?_________ ________________________________ | | |
| Has your child ever worn any orthodontic appliances?___________________________ | | |

| | Yes | No |
|---|---|---|
| Does your child brush his/her teeth daily? AM PM both (circle) | | |
| Do you assist with the tooth brushing? | | |
| Do you use dental floss? | | |
| Is fluoride used in any form? toothpaste, water, rinses, supplements (circle) | | |
| Does your child use a bottle/sippy cup ? What is in the bottle?__________________ | | |
| Does your child go to sleep with a sippy cup or bottle? | | |

Are there any religious/moral beliefs that may limit our ability to fully treat your child? NO YES ________________

# Office Policies

**FINANCIAL:** Your child's treatment plan will include a breakdown of all applicable fees, and we will inform you of all costs before treatment is administered. We accept cash, checks, Visa, MasterCard and Discover. A fee of $35.00 will be assessed on any returned checks.

**DENTAL INSURANCE-** We want you to get the most benefit from your dental insurance plan. If we have all of your insurance information on the day of the appointment and the ability to verify your coverage, we will file your insurance as a courtesy. Please be familiar with your insurance benefits because benefits change throughout the year based on the renewal date for that particular employer. If you do not have your insurance information, you will be responsible for the fees incurred at the time of the visit. We will then give you a receipt that you can submit to your insurance company for reimbursement.

Dental insurance does not cover all costs for dental services. Some companies pay fixed fees for certain procedures, while others pay a percentage of the charges. What your dental insurance covers has been negotiated between your employer and the dental insurance company. We will estimate what your insurance will cover and let you know what your anticipated liability is. That liability is due at the time services are rendered. After receiving payment from you insurance company, if there is an overpayment, a refund will be sent promptly, if there is still a balance due, a statement of your account will be sent for you to remit. It must be noted, that all fees incurred are ultimately your responsibility. Most importantly, please keep us informed of any insurance changes such as policy name, insurance company address or a change of employment.

**DELINQUENT ACCOUNTS-** If collection action is necessary on your account, you will be liable for interest of 1.5% per month on all outstanding balances, as well as any fees incurred for collecting said account. Those fees shall include, but not be limited to attorney's fees, court costs, as well as collection agency fees.

**APPOINTMENTS AND CANCELATIONS:** When we make your appointment, we are reserving a room and preparing treatment for your particular needs. We ask that if you must change an appointment, please give us at least 24 hours notice.

**Repeated cancellations or missed appointments will result in loss of future appointment privileges.**

**I understand that I am responsible for all costs of dental treatment not paid by insurance. I have read and understand my financial obligation to Crozet Pediatric Dentistry.**

**Signature:** ______________________________________________________________________**Date:** __________

**CLIFFORD CLUB:** If your child qualifies for our "Clifford Club" (reward/cavity free club) may we have your permission to place their first name on our website or our Facebook page? **NO** ______ **YES** _________

**CONSENT FOR DENTAL TREATMENT:** I hereby authorize Dr. Clifford and staff to administer therapeutic procedures and related medications, and to perform diagnostic and photographic procedures that are necessary for proper dental care. I grant Dr. Clifford to release my dental/medical histories and other information about my dental treatment to third party payers and/or other health professionals.

**To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/her medicines, I will inform the doctor at the next appointment without fail.**

**Signature:** ______________________________________________________________________**Date:** ___________

**NOTICE OF PRIVACY PRACTICES:** By signing below I acknowledge that I have received and reviewed a copy of this office's Notice of Privacy Practices according to federal and state requirements and I consent to the use of my records and information to carry out treatment, payment activities and healthcare operations as set forth in this office's Privacy Policy.

**Signature:** ______________________________________________________________________**Date:** ____________

Are you the child's legal guardian? YES NO (circle)