Children's Dental Health of Lynchburg
New Patient Questionnaire and Consent

PATIENT INFORMATION

Child's First Name:______________________ Middle Initial:_______ Last Name:______________________

Child's Preferred Name:______________________________SSN#:_________________________________

Male/Female (Circle one) Date of Birth:______________________ Age:_____________

HomeAddress:____
STREET CITY STATE ZIP

Parent/Legal Guardian Name:____

Name of Person Bring Child to Appointment: ____

How are you related to Patient: _____________________________

Do you have legal custody of the child? YES NO

Parent's Primary Phone Number:____

If any, names and ages of siblings:____

MEDICAL HISTORY

Child's Physician:__________________________________ Physician phone number:___________________

Is your child being treated for any medical or mental health issues? YES NO

If yes, please explain:____

Is your child taking any prescription medications? YES NO

If yes, please list medications:____

Does your child have allergies to medications or the environment? YES NO

If yes, please explain:____

Has your child ever been hospitalized? YES NO

If yes, please explain:____

Does your child have any of the following (circle all that apply)

HEART DISEASE	PROLONGED BLEEDING	SLEEP APNEA
HEART MURMUR	ASTHMA/BRONCHITIS	LOSS OF CONSCIOUSNESS
RHEUMATIC FEVER	DIABETES	FAINTING
KIDNEY PROBLEMS	AUTISM	SEIZURES
LIVER DISEASE	RESPIRATORY PROBLEMS	EMOTIONAL PROBLEMS
HEPATITIS	CANCER	CEREBRAL PALSY
HIV/AIDS	COLD SORES	SPEECH DIFFICULTIES
MALABSORPTION SYNDROME	PREGNANT	ADD/ADHD

Are there any other illnesses not listed above? YES NO

If so, please explain: ____

DENTAL HISTORY

1. Does your child have a toothache or other dental problems? YES NO

   If yes, please explain:____

2. My child sucks their thumb/fingers YES NO
3. Do you have any objection to taking diagnostic x-rays of your child's teeth? YES NO
4. Would you like sealants on your child's permanent molars? YES NO

   (if insurance covers, must be 5 years old)

INSURANCE INFORMATION

Father's Name:________________________ Home Phone:__________________Cell

Phone:_____________________

Father's SSN: ________________________

Employer:____

Mother's Name:_______________________ Home Phone:__________________Cell

Phone:_____________________

Mother's SSN:________________________

Employer:____

In order to keep our fees reasonable, we do not bill for services rendered. Our policy is that you pay for treatment prior to services performed. Please check the appropriate Dental Insurance Plan you wish to use.

NO INSURANCE______ PRIVATE INSURANCE______ MEDICAID______

FOR PRIVATE INSURANCE ONLY, please provide the following policy holder's information:

Policy Holder Name:______________________________ DOB: __________________ SSN:

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Employer: ____________________________________ Dental Insurance Carrier:

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CONSENT

Your child is a minor, therefore, it is necessary that a signed consent be obtained from parent or legal guardian before any necessary dental services can be started. I grant Children's Dental Health of Lynchburg permission to provide my child's dental exam and treatment, and I will be responsible for the cost of this dental care.

Sign:____ Date: ________________________________

By signing this agreement, I understand that I am responsible for ALL fees incurred by services performed by Children's Dental Health of Lynchburg. I also understand that if my account balance becomes delinquent at any time, the outstanding amount can/will be transferred to a collection agency/attorney for recovery of the debt. If that occurs, I understand I will be charged interest in the amount of 24% annually, collection and/or reasonable attorney fees and any court fees which may occur with the collection of this amount due.

Sign: ____ Witness: ____