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 Bringing Child to Appointment: _____

How are you related to Patient: _____

Do you have legal custody of the child? YES NO

Primary Phone Number:_____ Alternate Phone Number: _____

If any, names and ages of siblings:_____

MEDICAL HISTORY

Child's Physician:_____

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. Would you like sealants on your child's permanent molars if insurance covers the treatment ? *(Your child must be at least 5 years old)* YES NO

INSURANCE INFORMATION

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_____

Father's Name:_____ Home Phone:_____Cell Phone:_____

Father's SSN: _____ Employer:_____

Mother's Name:_____ Home Phone:_____Cell Phone:_____

Mother's SSN:_____ Employer:_____

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

Policy Holder Name:_____ DOB: _____

SSN: _____ Employer: _____

Dental Insurance Carrier: _____ Policy ID Number: _____

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 understand that today's visit is for a comprehensive dental examination, cleaning, fluoride, and x-rays (if needed).

This office follows the guidelines of the American Academy of Pediatric Dentistry and recommends x-rays taken every 1-2 years. Current x-rays are necessary for a comprehensive dental examination. No restorative work will be scheduled without current x-rays. No exceptions. 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: _____