Lovettsville Dental Arts

Welcome

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we ll be glad to help you. We look forward to working with your child.

Patient Information

Child's Name _____ Social Security # _____
LAST NAME FIRST NAME INITIAL

Address _____

City _____ State _____ Zip _____ Home Phone _____

Sex ❑ M ❑ F Age _____ Birthdate _____ School _____

Grade _____ Hobbies / Sports _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Work Phone _____

Primary Insurance

Person Responsible for Account _____
LAST NAME FIRST NAME INITIAL

Relation to Patient _____ Birth date _____ Social Security # _____

Address (if different from child) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____

Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Insurance Company _____ Phone _____

Contract # _____ Group # _____ Subscriber _____

Name of the other dependents under this plan _____

Additional Insurance

Is patience covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birth date _____

Address (if different from patient) _____ Social Security # _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Email _____

Insurance Company _____ Phone _____ Insurance Email _____

Contract # _____ Group # _____ Subscriber _____

Name of the other dependents under this plan _____

_____

PLEASE COMPLETE PAGE 2

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____
Former Dentist _____ Dentist's Phone _____
Address _____ Email Address _____
Date of last dental care _____ Date of last x-rays or digital image _____
How often does your child brush? _____Floss? _____
Does your child experience pain or discomfort in the jaw joint? ❑ **Yes** ❑ **No**
Has your child ever experienced a mouth or chin injury? ❑ **Yes** ❑ **No**
Does your child have speech problems? ❑ **Yes** ❑ **No**
Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ **Yes** ❑ **No**
Other information about your dental health or previous treatment _____
_____

Medical History

Child's Physician's _____ Phone _____
Date of last visit _____ Has your child had any serious illnesses or operations? ❑ **Yes** ❑ **No**
If yes describe _____
Is your child currently under a physician care? ❑ **Yes** ❑ **No** If Yes Describe _____
Has your child ever had a blood transfusion? ❑ **Yes** ❑ **No** If yes approximate dates _____
Has your ever taken Fen-Phen Redux? ❑ **Yes** ❑ **No**
Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva ❑ **Yes** ❑ **No**

Check (✔) Yes or no if your child has had any of the following:

❑ **Yes** ❑ **No** AIDS /HIV Positive
❑ **Yes** ❑ **No** Anemia
❑ **Yes** ❑ **No** Asthma
❑ **Yes** ❑ **No** Atopic (Allergy prone)
❑ **Yes** ❑ **No** Blood disease
❑ **Yes** ❑ **No** Cancer
❑ **Yes** ❑ **No** Chicken Pox
❑ **Yes** ❑ **No** Convulsions/Epilepsy
❑ **Yes** ❑ **No** Back problems
❑ **Yes** ❑ **No** Cough, persistent
❑ **Yes** ❑ **No** Cough up blood
❑ **Yes** ❑ **No** Diabetes
❑ **Yes** ❑ **No** Epilepsy
❑ **Yes** ❑ **No** Fainting
❑ **Yes** ❑ **No** Food Allergies
❑ **Yes** ❑ **No** Headaches
❑ **Yes** ❑ **No** Hearing Impairment
❑ **Yes** ❑ **No** Heart problems
Describe _____
_____
❑ **Yes** ❑ **No** Hemophilia / Abnormal bleeding
❑ **Yes** ❑ **No** Immunizations current
❑ **Yes** ❑ **No** Liver disease or malfunction
❑ **Yes** ❑ **No** Liver disease
❑ **Yes** ❑ **No** Material Allergies (***latex***, wool, metal, chemicals)
❑ **Yes** ❑ **No** Respiratory disease
❑ **Yes** ❑ **No** Rheumatic / Scarlet fever
❑ **Yes** ❑ **No** Shortness of breath
❑ **Yes** ❑ **No** Sinus problems
❑ **Yes** ❑ **No** Skin rash
❑ **Yes** ❑ **No** Spina Bifida
❑ **Yes** ❑ **No** Thyroid disease or malfunction
❑ **Yes** ❑ **No** Tonsillitis
❑ **Yes** ❑ **No** Tuberculosis
❑ **Yes** ❑ **No** Other

Are you currently taking any medications? If yes list all:
_____
_____

Do you have any drug allergies? If Yes, list all:
_____
_____

Authorization

I have reviewed the information on the questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
Signature _____ Date _____

Payment is due in full at the time of treatment, unless prior arrangements have been approved.