CHILDREN'S DENTAL CARE

803 Russell Ave, Suite 2A Gaithersburg, MD 20879
PEDIATRIC AND ADOLESCENT DENTAL CARE
We love kids and know how to care for them!

Welcome To Our Office!

Thank you for trusting us with your children's dental care. Our goal is to make every child's visit comfortable and educational. We strive to teach your child good oral care, which will help keep their smiles beautiful for a lifetime.

CHILDREN'S INFORMATION

TODAY'S DATE _____

Patient's Name: _____ (Last / First / Middle) Nickname: _____

Date of Birth: _____ Age: _____ Sex: **F** **M**

School: _____ Grade: _____

Child's Home Phone Number: _____

Child's Home Address: _____ City: _____ State: _____ Zip: _____

Name and Age of Brothers/Sisters: _____

Interests or hobbies: _____

Whom may we thank for referring you? _____

Person Responsible for the Account: _____ Relationship: _____

Home Number: _____ Work Number: _____ ext: _____ SSN: _____

Parent's Marital Status: Single Married Divorced Separated Widowed

PARENTS INFORMATION

☐ *Mother* ☐ *Stepmother* ☐ *Guardian*

Name: _____ DOB: _____

Wk #: _____ **Cell #:** _____ Hm #: _____

Employer: _____

Occupation: _____

SS#: _____ **Email:** _____

☐ *Father* ☐ *Stepfather* ☐ *Guardian*

Name: _____ DOB: _____

Wk #: _____ **Cell #:** _____ Hm #: _____

Employer: _____

Occupation: _____

SS#: _____ **Email:** _____

INSURANCE INFORMATION

Maryland Healthy Smiles Dental Program

Member ID#: _____ Insurance Co. Name: _____

Ins. Co. Address: _____ Ins. Co. Phone #: _____

Policy Owner's Name: _____

Policy Owner's DOB: _____ SSN: _____

[Continued on back]

Name: _____ **DOB:** _____

[Continued from front]

DENTAL HISTORY

Why did you make this appointment? _____

Has your child ever had an unpleasant dental experience? ☐ No ☐ Yes _____

Have your child's teeth ever been injured? ☐ No ☐ Yes _____

Were there any problems with the birth or pregnancy? ☐ No ☐ Yes _____

Have the child ever had any pain/tenderness or popping noise in his/her jaw joint? ☐ No ☐ Yes _____

Is the child nervous about this appt? ☐ No ☐ Yes

Is the child's drinking water fluoridated? ☐ No ☐ Yes

Is the child taking fluoridated supplements? ☐ No ☐ Yes

Does the child brush his/her teeth daily? ☐ No ☐ Yes

Do you help your child brush? ☐ No ☐ Yes

Does the child floss his/her teeth daily? ☐ No ☐ Yes

Was the child breast fed? ☐ No ☐ Yes

Does/Did the child have any of the following habits:

☐ Bottle to bed at night ☐ Use a pacifier

☐ Thumb/finger sucking ☐ Lip sucking/biting

☐ Mouth breathing

☐ Other: _____

Date of last dental exam: _____

Name of previous dentist: _____

MEDICAL HISTORY

Are you currently under the care of a physician? ☐ No ☐ Yes Date of last dental exam: _____

Physician: _____ Phone #: _____ Address: _____

Do your child have any history of the following diseases or conditions?

	No	Yes		No	Yes		No	Yes
Abnormal Bleeding	☐	☐	Cerebral Palsy	☐	☐	Hepatitis/Liver Problems	☐	☐
Accidents/Severe Infections	☐	☐	Convulsion/Seizures	☐	☐	Kidney/Bladder Problems	☐	☐
Any hospital stay/operations	☐	☐	Diabetes	☐	☐	Mental Retardation	☐	☐
Anemia/Blood Disorders	☐	☐	Eye Problems	☐	☐	Measles/Chicken Pox	☐	☐
HIV/AIDS	☐	☐	Emotional/Behavioral Prob.	☐	☐	Rheumatic/Scarlet Fever	☐	☐
Asthma/Lung Problems	☐	☐	Handicaps/Disabilities	☐	☐	Speech/Learning Disorder	☐	☐
Cancer/Tumors	☐	☐	Heart Murmur/Congenital Heart Defect	☐	☐	Tuberculosis	☐	☐

Please describe any serious medical problems that your child may have: _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

Anything you would like to discuss with the Doctor in private? ☐ No ☐ Yes

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and sign directly to Dr. Tong all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____ Relationship: _____ Date: _____

Responsible Party Signature

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein: _____

Reviewer: _____ Date: _____

Doctor's Comments: _____