pediatric dental care

Welcome! to the Orthodontist

Fairfax: 9901 Fairfax Blvd., Fairfax, VA 22030 P: 703.383.34
Springfield: 6120 Brandon Ave., Ste 114, Springfield, VA P:703.992.7100
Chantilly: 24805 Pinebrook Rd., Suite 108, Chantilly, VA 20152 P: 703.957.3190
www.myPDCdentists.com

1 Tell us about your child

Today's Date _____

Child's Name _____
LAST FIRST M. INITIAL

Child's Birthdate _____ Child's Age _____

Nickname _____ ☐ Male ☐ Female

School _____ Grade _____

Hobbies/Sports _____

Child's Home # _____ SS# _____

Child's Home Address _____

_____
CITY STATE ZIP

2 Who is accompanying the child today?

Name _____ Relation _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

List brothers /sisters with age _____

_____

General Dentist _____

Last Exam Date _____ Any Cavities? _____

Parent's Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

3 Parent's Information

Mother ☐ Step Mother ☐ Guardian

Name _____ Birthdate _____

Check which number is best to contact you.

☐ Home _____ ☐ Work _____ ☐ Cell _____

Employer _____

How long at your current job? ____ Job Title? _____

SS# _____ DL# _____

Email

Father ☐ Step Father ☐ Guardian

Name _____ Birthdate _____

Check which number is best to contact you.

☐ Home _____ ☐ Work _____ ☐ Cell _____

Employer _____

How long at your current job? ____ Job Title? _____

SS# _____ DL# _____

Email

4 Person Responsible for account

Name _____ Relation _____

Billing Address _____

_____
CITY STATE ZIP

Previous Address _____

Hm# ( ) _____ DL# _____

Employer _____

Wk# ( ) _____ Ext. _____ SS# _____

Who is responsible for making appointments?

Name _____ Birthdate _____

Wk# ( ) _____ Ext. _____ Hm# _____

Neighbor of relative not living with you

Name _____ Phone _____

Address _____

_____
CITY STATE ZIP

5 Primary Dental Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group# (Plan, local,or Policy#) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ S.S# _____

Policy Owners Employer _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No Ortho Coverage? ☐ Yes ☐ No

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone# _____

Group# (Plan, local,or Policy#) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate _____ S.S# _____

Policy Owners Employer _____

All accounts sent to collections will be charged the account balance plus an additional 50%, based on the account balance.

6 What are the main concerns that you would like orthodontics to accomplish?

Has the child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No

Have there been any injuries to the mouth, teeth or chin? ☐ Yes ☐ No

List any musical instruments played

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra teeth permanent teeth? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMI/TMD)? ☐ Yes ☐ No

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

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone#: _____ Date of last visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Has puberty begun? ☐ Yes ☐ No

Has menstruation begun? (girls) ☐ Yes ☐ No

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

Please list all drugs that the child is currently taking:

Please list all drugs/things that the child is allergic to:

7 Has you child ever had any of the following medical problems:

Y N Abnormal Bleeding
Y N Allergies to any drugs
Y N Allergic to Latex/Medals
Y N Allergic to plastics
Y N Any hospital stays
Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV+/ AIDS
Y N Kidney/ Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Tuberculosis(TB)

Please discuss any serious medical problems that the child has had: _____

8 Does/did the child have any of the following

Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/ Finger Sucking
Y N Tongue Thirst

9

I understand that the information that I have given is correct to the best of my knowledge, that it well be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

SIGNATURE OF PARENT OR GUARDIAN DATE

This office reserves the right to verify the credit status of potential patients and/or prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting agencies.

SIGNATURE OF PARENT OR GUARDIAN DATE

The parent or guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made. Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDA and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally retrieved the medical / dental information above with the parent/guardian & patient named herein.

Doctor's Comments Initials _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices; Consents to Communications

TO BE COMPLETED BY THE PATIENT OR THE PATIENT'S PERSONAL REPRESENTATIVE (E.G., PATIENT'S PARENT OR LEGAL GUARDIAN)

Last Name _____ First Name _____ Middle Name _____

Date of Birth _____ Home Phone _____ Mobile Phone _____

Email Address _____ Patient Name (if completed by Personal Representative) _____

	Yes	No
I acknowledge receipt of this dental office's ("Practice") Notice of Privacy Practices.	☐	☐
I consent to receive recall appointment reminder information at the mailing address on file with the Practice.	☐	☐
I consent and agree to receive calls and text messages from or on behalf of the Practice and its affiliates at the home and/or mobile phone numbers provided above. These calls and text messages may include (but are not limited to) those concerning my health care, my account and insurance, and the Practice's services and may include marketing content. These calls and texts may be placed using automatic dialing or pre-recorded/artificial voice technology, and standard message or data rates may apply. I understand that my consent is voluntary and is not a required condition for receiving care from the Practice. I understand that I can unsubscribe at any time by calling the Practice or replying "STOP" to a text message from the Practice or its applicable affiliate.	☐	☐
I consent to receive voice messages from the Practice and its affiliates containing health information at the home and/or mobile phone numbers provided above.	☐	☐
I consent to receive email communications from or on behalf of the Practice and its affiliates at the email address provided above. I understand that these communications may include (but are not limited to) operational notices about my account and insurance and are part of my relationship with the Practice. I also understand that these communications may include promotional communications, including, but not limited to, newsletters, information about new services or suggested screenings, special offers, surveys and other news and information that the Practice thinks will be of interest to me. I understand that I may opt out of receiving promotional emails at any time by following the unsubscribe instructions provided therein. I understand that if I opt out of receiving promotional communications from the Practice, I may still receive transactional communications, including emails about my account or relationship with the Practice.	☐	☐

I permit the Practice to share appointment, billing, and general dental/health information with the following individual(s) who are involved in my (or, if I am the patient's personal representative, the patient's) care (*e.g.*, a family member, friend, caregiver):

_____

I understand that I may revoke any of the above consents at any time by so advising the Practice in writing. My revocation of any consent will not affect my (or, if I am the patient's personal representative, the patient's) ability to receive services from Practice.

_____ _____

Signature of Patient / Personal Representative ***If Personal Representative, relationship to Patient***

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

☐ Patient / Personal Representative refused to sign form ☐ Other: _____

_____ _____

Signature of Office Manager Date

pediatric dental care

www.myPDCdentists.com

APPOINTMENT POLICY

Please be advised:

In order to avoid a broken appointment fee of $50.00, please call the office to cancel or reschedule all appointments that you are unable to commit to. You can do this by phone or in person in the office. This **MUST BE DONE AT LEAST 24 HOURS PRIOR TO THE APPOINTMENT.**

If you are an orthodontic patient (in braces) this could also delay your treatment and incur additional charges.

By signing below, I acknowledge that I understand and agree to the broken appointment policy.

_____ _____

PATIENT NAME **DATE**

_____

PATIENT SIGNATURE