**9901 Fairfax Blvd., Fairfax, VA 22030 P:(703) 383-3434 F: (703) 383-3113**
**6120 Brandon Avenue, Suite 114, Springfield, VA 22150 P:(703) 992-7100 F: (703) 992-7137**

Today's Date: _______/______/___________ Office Location ☐ Fairfax ☐ Springfield

## Health Information

**Child's Name**: ___________________________________________________________ Nickname: _________________________
Last First MI

Age: _________________ Date of Birth: ________________________________________ Gender: _____________________________________

Mailing Address: ___________________________________________________ City: _________________State: ________Zip: ___________

Home Phone: __________________________________________ Parent's Mobile Phone__________________________________________

Parent's Email (s): _______________________________________________________________________________________________

- Is your child's water fluoridated? ☐ Yes ☐ No
- Is your child taking any fluoride supplements? ☐ Yes ☐ No
- Has your child ever had any jaw pain or tenderness? ☐ Yes ☐ No
- Does your child brush their teeth daily? ☐ Yes ☐ No
- Does your child floss their teeth daily? ☐ Yes ☐ No

Does your child have any of the following habits?
Thumb/ Finger sucking/ Pacifier ☐ Yes ☐ No
Nail biting ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Nursing bottle habits/ Breast-feeding ☐ Yes ☐ No

- Is your child now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________________________________________________________
- Name of Physician/Specialty: ____________________________________ Phone: ___________________________________
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________________________________________________________
- Has your child been admitted to hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________________________________________________________
- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________________________________________________________

**Has your child ever had any of the following?** (These questions help us to treat and better understand your child.) **Please check those that apply:**

☐ AIDS / HIV+
☐ Allergies ___________
☐ Anemia
☐ Asthma
☐ Autism
☐ Blood Disease
☐ Cancer_____________
☐ Cleft Lip/Palate
☐ Congenital Heart Defect
☐ Diabetes
☐ Dizziness
☐ Ear Aches
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Frequent Headaches
☐ Handicap / Disabilities
☐ Head Injuries
☐ Hearing Impaired
☐ Heart Disease
☐ Heart Murmur
☐ Hemophilia
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Learning Disabilities (A.D.D. Dyslexia, Hyperactivity)
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Seizure
☐ Sore Throat
☐ Speech Problems
☐ Stomach Problems
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors
☐ Up to Date Immunizations
☐ Latex Allergy
☐ Penicillin Allergy

OTHER:
☐ ______________
☐ ______________

Pediatrician(s) Name: ___________________________________________________ and/or Group Name: ________________________________
Address: ____________________________________________________________ Phone: _________________________________________
Child's Previous Dentist: _______________________________________________and/ or Group Name: ________________________________
Address: ____________________________________________________________ Phone: _________________________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child's health changes, I will inform the doctors at the next appointment without fail.

**Name:** _______________________________________________________ **Relationship to Patient:** ______________________________

**Signature:** ___________________________________________________ **Date:** _______________________________________________