Patient Medical History
Commonwealth Pediatric Dentistry

a division of Central Virginia Dental Care, PLC

6661 Lake Harbour Drive	7032 Forest Hill Avenue	201 A Street
Midlothian, VA 23112	Richmond, VA 23225	Farmville, VA 23901
804-729-0792(phone) 804-729-0861(fax)	804-621-8299(phone) 804-932-0009(fax)	434-808-1657(phone) 434-710-4030(fax)

Patient Information – We welcome your child into our practice, and we will try to make his/her dental experiences very pleasant. Please complete this for thoroughly because this information is of great value in helping us to better understand and care for your child

Patient Name____ Nickname _______________ Appointment Date _______________

LAST FIRST MI

□ Male □ Female Date of Birth ____________________ Age _______ Siblings & Ages ____

Home Phone ( ) ___________________________ School ____ Grade ________

Address ____

STREET APT NO.

____

CITY STATE ZIP

Email Address ____

Health Information – Has your child ever had any of the following? Please check those that apply.

□ AIDS	□ Cerebral Palsy	□ Kidney Problems	□ Speech Problems
□ Allergies: Drug or Latex	□ Chicken Pox	□ Liver Problems	□ Thyroid Disorder
____________________	□ Diabetes	□ Lung Problems	□ Tuberculosis
□ Anemia	□ Emotional Disorder	□ Mental Retardation	□ Vision Problems
□ Asthma	□ Epilepsy	□ Mononucleosis	□ Other ______________
□ Behavioral Problems	□ Hearing Problems	□ Mumps/Measles	□ Medications
□ ADHD □ Autism	□ Hepatitis	□ Pregnancy	________________________
□ Bleeding Disorders	□ Heart Conditions	□ Respiratory Problems	________________________
□ Blood Transfusion	□ Hospitalization	□ Rheumatic Fever	________________________
□ Cancer	□ Immunizations up-to-date	□ Sinus Problems	________________________

Pediatrician Name ____ Last Visit ___________________ Phone__________________

Has your child been seen by another dentist? □ No □ Yes, Name ____

Date of last visit _____________________________ Phone ____

Has your child had an unfavorable dental experience? ____

Does your child have a past or current history thumb/finger sucking? □ Yes □ No Pacifier □ Yes □ No

Was your child breast fed? □ Yes □ No Bottle Fed? □ Yes □ No Age discontinued? ______________________________

What is your home water source? □ Public System □ Private Well □ Other ____________________________________

Consent For Services – As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends on the reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of patient examination.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate therto. This consent shall remain in full force and effect until cancellation by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefit be denied.

I have read the above conditions of treatment and agree to their content.

____ **Date**_____________________ **Relationship to Patient** ______________________________________

SIGNATURE OF PARENT/GUARDIAN

(continue to back of form)

Parent/Guardian Information

Father's Name ____ ☐ Married ☐ Single
LAST ` FIRST MI
Social Security Number __________________ Birthdate ____________ Driver's License No. ______________

Phone: Home ( ) ______________ Work ( ) ________________ Mobile ( ) ________________

Address ____
STREET APT NO.

____
CITY STATE ZIP

Employer Name ______________________________ Occupation ______________________

Employer Address ____
Street City State Zip

Mother's Name ____ ☐ Married ☐ Single
LAST ` FIRST MI
Social Security Number __________________ Birthdate ____________ Driver's License No. ______________

Phone: Home ( ) ______________ Work ( ) ________________ Mobile ( ) ________________

Address ____
STREET APT NO.

____
CITY STATE ZIP

Employer Name ______________________________ Occupation ______________________

Employer Address ____
Street City State Zip

Emergency Information – Nearest relative not living in same household.

Name ______________________________________ Phone ( ) ____________________

Address ____

Primary Insurance Information

Name of Insured ____
LAST FIRST MI
Insured's Birthdate ______________ ID No. ____________________ Group No. ________________

Insured's Employer Name ____

Employer Address ____
Street City State Zip
Patient's Relationship to Insured ☐ Self ☐ Spouse ☐ Child ☐ Other ______________________________

Insurance Plan Name and Address ____

______________________________ Insurance Company's Phone ____________________

I hereby authorize payment of the dental benefits otherwise payable to me, directly to Commonwealth Pediatric Dentistry, a division of Central Virginia Dental Care, PLC
Signature of Employee/Subscriber ________________________

Referral Information – Whom may we thank for referring you to our practice?

☐ Another Patient (friend) ☐ Another Patient (relative) ☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work

☐ Other ____________________ Name of person or office referring you to our practice? ____________________