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Growing Smiles OF NORTHERN VIRGINIA

New Patient Form

Today's Date: MM/DD/YYYY

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service

1. Tell Us About Your Child

Child's Name:

Goes by: Male ◯ Female ◯

Siblings That We Treat:

Child's Birthdate: DD/MM/YYYY Child's Age:

School:

Child's Home Phone #:

SSN:

Child's Home Address:

2. Legal Guardian #1 Information

Name:

Mother ◯ Father ◯ Stepparent ◯ Guardian ◯

Birthdate: DD/MM/YYYY

Address:

Employer:

Work Phone #:

Home Phone #:

Cell Phone #:

SSN: DL #:

Email Address:

3. Legal Guardian #2 Information

Name:

Mother ◯ Father ◯ Stepparent ◯ Guardian ◯

Birthdate: DD/MM/YYYY

Address:

Employer:

Work Phone #:

Home Phone #:

Cell Phone #:

SSN: DL #:

Email Address:

4. Who May We Thank for Referring You?

5. Who Is Accompanying Your Child Today?

Name:

Relationship:

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

6. Person Responsible for Account

Name:

Relationship:

Billing Address:

Work Phone #:

Home Phone #:

Cell Phone #:

Email Address:

7. Primary Dental Insurance

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: DD/MM/YYYY

SSN:

Policy Owner's Employer:

8. Secondary Dental Insurance

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: DD/MM/YYYY

SSN:

Policy Owner's Employer:

9. Dental History

Is this your child's first visit to the dentist? Yes ◯ No ◯

If not, how long since the last visit to the dentist? _____

Previous dentist's name: _____

Were any x-rays taken at previous dental visits? Yes ◯ No ◯

Have there been any injuries to the teeth, face or mouth? Yes ◯ No ◯

If yes, please explain:

Why did you bring your child to the dentist today?

Does the child have any of the flowing habits?

- ☐ Lip sucking / Biting
- ☐ Nail Biting
- ☐ Nursing / Bottle Habits
- ☐ Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes ◯ No ◯

If yes, please explain:

- ☐ Is the child's water fluoridated?
- ☐ Is the child taking fluoride supplements?
- ☐ Has the child ever had any pain or tenderness in his/her jaw/joint (TMJ/TMD)?
- ☐ Does the child brush his/her teeth daily?
- ☐ Floss his/her teeth daily?

10. Health History

Has the child every had any of the following conditions?

- ☐ Abnormal Bleeding
- ☐ Allergies to any Drugs
- ☐ Any Hospital Stays
- ☐ Any Operations
- ☐ Asthma
- ☐ Cancer
- ☐ Congenital Birth Defects
- ☐ Convulsions/Epilepsy
- ☐ Pregnancy
- ☐ Tuberculosis
- ☐ ADD/ADHD
- ☐ Autism
- ☐ Handicaps/Disabilities
- ☐ Hearing Impairment
- ☐ Heart Disease/Murmur
- ☐ Hepatitis
- ☐ HIV +/AIDS
- ☐ Kidney/Liver Conditions
- ☐ Rheumatic/Scarlet Fever
- ☐ Allergies to Latex Product
- ☐ Diabetes
- ☐ Hemophilia/Blood Disorders
- ☐ Reflux/GI problems

Please discuss any serious medical conditions the child had:

Please list all the drugs the child is currently taking:

Please list all drugs the child is allergic to:

Have you or any of your household members traveled outside the US within the last 60 days? If yes, where?

Child's physician: _____

Phone #: _____

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

Please describe the child's current physical health:

Good ◯ Fair ◯ Poor ◯

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

I understand that the information I have give is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any change in my child medical status.

I authorize the dental staff to perform the necessary dental service my child may need.

Date: DD/MM/YYYY

Relationship to Patient: _____

Signature of Patient or Guardian:

Click icon on the toolbar to add the digital signature. _____