NOVA
PEDIATRIC DENTISTRY
& ORTHODONTICS
BRINGING SMILES TOGETHER

21785 Filigree Court, Suite 208
Ashburn, VA 20147
Phone: 703.729.7005
Fax: 703.729.5799

Patient Name:

Date of Birth:

Reason for Today's Visit:

In order to ensure that your child receives the best care at our practice, we ask you to carefully complete this form. It is important for us to know about all parts of your child's health history. This form is completely confidential, and will be used only for dental and medical reasons.

PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name:________________________________Nickname:_____________________Sex:___________

Age: ________ Birthdate:______________ Interests/Hobbies/Pets: __________________________________

Mailing Address:_________________________________City:________________State: _____ Zip:___________

Home Telephone: ______________________ Parent's Mobile Phone: ________________________________

Parent Email(s): ____

May we contact you through email? Yes_________ or No _________

Responsible Party: ____

Mother's Name: ______________________ Occupation: _________________ Work Phone: ____________

Father's Name: ________________________ Occupation: _________________ Work Phone: __________

Parent's Address (if not living at above) ____

Who has legal custody of patient: ____Mother _____ Father _____ Joint _____ Other ______

What is the parent's primary language? ______________________ The child's? _________________________

Date of Adoption, if applicable: _________________

Names and ages of brothers and sisters: ____

Whom may we thank for referring you? ____

If the referral was from a Physician/Pediatrician/Dentist, please name the practice: ______________________

Whom may we contact in case of emergency?

Name: ______________________________ Relationship: __________________ Phone: ________________

HEALTH PROVIDERS

Child's Physician/Pediatrician: _________________________________ Phone#: ______________________

Mailing Address: ___________________________ City: __________________ State:_____ Zip: ____________

Child's Previous Dentist: ________________________________ Phone#: ____________________________

Mailing Address: ______________________________ City: ________________ State:_____ Zip: __________

Patient Name:____

DENTAL HISTORY

1. If your child has been to a dentist previously:

When was last visit? ___________ Have X-rays been taken? ☐Yes ☐No When: _________

2. How did your child react?____

3. Has your child had local anesthetic ("Novocaine"?) ☐Yes ☐No

Were there any problems? ____

4. How old was your child when his/her first tooth erupted? ______________________

5. **Fluoride**: Has your child had fluoride in any of the following forms:

Fluoride tablets or fluoride multivitamins………………………………………….. ☐Yes ☐No

If yes, at what age did he/she start taking them? _______ Is he/she still taking them? ☐Yes ☐No

Drinking water (community/tap water fluoridation)…………………………………... ☐Yes ☐No

Professional topical application……………………………………………………….. ☐Yes ☐No

6. **Brushing:** Does your child brush his/her own teeth?…...………...……………………… ☐Yes ☐No

When does he/she brush? ☐A.M. ☐P.M. ☐After meals

Do you help in brushing your child's teeth?…………………………………………… ☐Yes ☐No

How much toothpaste does your child use? _______________ Does he/she swallow it? ☐Yes ☐No

Do you or your child use dental floss in cleaning their teeth?……………………… ☐Yes ☐No

How often? ____________________________________

What kind of toothbrush does he or she use? ☐Hard ☐Soft ☐Battery

7. **Diet:** Does your child snack frequently?…………..…………………………………….. ☐Yes ☐No

What do those snacks consist of and how often?______________________________________

How much soda and juice does your child usually drink per day? ________________

Was/is your child allowed to carry a bottle/cup throughout the day containing something other than plain water? ☐Yes ☐No

8. **Trauma**: Have your child's teeth ever been injured?... ☐Yes ☐No

When (age)? ____

Which teeth? ____

Cause? ____

Did he/she receive treatment?…………………………………………………… ☐Yes ☐No

If yes, describe treatment ____

9. **Habits**: Does your child have any of the following habits? (Indicate inclusive ages)

Bottle to sleep or nap containing ____ ☐Yes ☐No

Thumb or finger sucking (which thumb/finger _______________________________) ☐Yes ☐No

Pacifier sucking………………………...…………………..………………… ☐Yes ☐No

If yes, is it ever dipped in honey or other sweet substances? ……………………… ☐Yes ☐No

Mouth Breathing……………………………………………………….………… ☐Yes ☐No

Grinding of teeth…………………………………………………… ☐Yes ☐No

10. Has your child received any unusual dental or surgical treatment to the mouth? ☐Yes ☐No

If yes, describe: ____

11. Is there anything else you would like to tell us regarding your child's dental health?

____

____

Patient Name:_________________________________

MEDICAL HISTORY

12. Where there any difficulties during the pregnancy, delivery (e.g., prematurity) or 1st year of your child's life? If yes, describe?_______________________________ ☐Yes ☐No

13. Medical conditions: Does your child have any history of the following? *(Check all that apply)*

General conditions	***Developmental***	***Infectious***
☐Arthritis	☐Brain injury	☐Hepatitis
☐Asthma	☐Cerebral palsy	☐HIV infection (AIDS)
☐Diabetes	☐Cleft lip/palate	☐Tuberculosis
☐Gastrointestinal disorders	☐Developmental Delay	☐Venereal disease:
☐Heart disease	☐Feeding/Eating problems	Type_______________
☐Heart murmur	☐Growth problems	
☐Kidney disease	☐Hearing loss: Type _________	***Substance use/Abuse***
☐Rheumatic fever	☐Neuromuscular defect	☐Drug use
	☐Orthopedic problems	☐Tobacco use
Behavior/Learning	☐Seizures: Type____________	☐Abuse (physical or sexual)
☐ADHD	☐Speech prob: Type _________	
☐Anxiousness/Nervousness	☐Spina bifida	***Other***
☐Autism		☐Cancer: Type ____________
☐Behavior issues: Type_______	***Hematological (Blood-related)***	☐Leukemia: Type __________
☐Emotional disability:	☐Anemia	☐Fainting/headaches (often)
Type______________	☐Bleeding (prolonged)	☐Sleep apnea
☐Learning disability:	☐Hemophilia	☐Sleep problems
Type_______________	☐Sickle cell trait	☐Snoring
☐Psychiatric disorder:	☐Sickle cell disease	☐Syndrome: Type __________
Type________________	☐Transfusion of blood	☐Other: _________________

If any boxes checked, please describe further:____

____

____

14. Medications: Is your child CURRENTLY taking any medications?

Drug	How much & how often?	Reason

15. Steroid Use: Has your child had any steroid treatment in the past 6 months? ……………... ☐Yes ☐No

16. Allergies: Has your child had any allergic reactions to:

Medications or drugs? _____________________________________

Latex?____

Foods? ____

Other? ____

Patient Name:_______________________________________

17. Development/ Special needs:

Can your child talk and understand at his/her age level?…………………………..…… ☐Yes ☐No

Does your child attend a special class or school? If yes:_________________________ ☐Yes ☐No

Does your child use the following to help with walking? ☐Wheelchair ☐Walker ☐Other

If female, has your child had her first monthly period?……………………………….…… ☐Yes ☐No

18. Immunizations: Are your child's immunizations current?…………. …………………… ☐Yes ☐No

19. Have you ever been told that your child needs to take *antibiotics before dental treatment*? ☐Yes ☐No

20. Hospitalizations: Has your child ever been hospitalized?…………….. ………………….. ☐Yes ☐No

If yes, when, and where? ____

Reason for hospitalization? ____

21. Surgeries: Has your child had any surgery (operations)?……………………………….. ☐Yes ☐No

Date(s) and age(s)? ____

For what reason(s)? ____

Was general anesthesia used?………………………………………………………….. ☐Yes ☐No

Were there any complications? If yes: _____________________________________ ☐Yes ☐No

22. Are there any elevated stresses happening in your home? If yes:____________________ ☐Yes ☐No

23. Have you or your child ever felt threatened in your home?………………………………. ☐Yes ☐No

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status.

Name: ___________________________________

Signature: _________________________________**Relationship to patient:**______________**Date:**________

***Reviewed by*: Doctor**_______________________________________**Date:**____________________________

CONSENT FOR DENTAL TREATMENT

I am the parent, guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Valerie Woo and her staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, any necessary dental treatment for my child's teeth, X-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Dr. Woo, whether or not I am present when the treatment is rendered. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Woo will provide an environment that will help children learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. I will be responsible for any charges incurred for my child for dental treatment.

Signature:____ **Date:**_____________________________________

____

Please print name of Patient, Parent, Guardian, or Personal Representative **Relationship to Patient**

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FINANCIAL AGREEMENT

We believe that our Patient Financial Agreement is as important as the services that we perform. It is our responsibility to inform you of charges and our payment guidelines prior to treatment. Determining costs for insured patients is more difficult and less accurate. Your insurance is a contract between your employer and a dental insurance company. Benefits received are based on the terms of the contract negotiated between your employer and the dental insurance company, and not the dental office. The goal of most dental insurance policies is to provide only basic care for specific dental services and typically have little to do with your child's needs or achieving a high-quality, complete result. Many needed services may not be covered. Our office will do everything possible to help you understand and make the most of your dental benefits. As a courtesy, our office will complete and submit your insurance forms to achieve the maximum reimbursement to which you are entitled. **Please remember that you are ultimately responsible for all expenses incurred. We urge you to read your dental insurance policy so that you are fully aware of coverage and any limitations of the benefits provided.** _______ If an exact determination makes you more comfortable, the best method for accuracy is to pre-authorize the procedures with your carrier. We want our patients to be able to comfortably afford dental care. We will gladly discuss our payment options with you before beginning your treatment.

Dr. Woo and her staff are committed to providing excellent dental care and guiding parents in choosing the best payment option for their child's needs. We accept cash, personal checks, Visa, MasterCard, American Express, Discover, as well as offer Capital One Health Care Financing (a dental credit card). If paying by check, there will be a charge of $25 for any check that is returned due to insufficient funds. A check returned due to NSF may require a credit card number to be placed on file for future payments.

BROKEN APPOINTMENT POLICY

The time for your child's dental appointment has been exclusively reserved for you and your child. Without proper notification of your inability to be present for an appointment, some other child who has been waiting for dental care will not receive the dental care they need because we did not have adequate time to notify them of the available time. Therefore, we are requiring that at least **24 hours** notice be given, as a courtesy to us and to other patients, if your scheduled time is inconvenient. **The Broken Appointment fee will be $75, unless otherwise noted. Also, if you arrive to your appointment ten minutes late we reserve the right to reschedule your appointment.**

The patient and/or responsible party have received, read, and understand the financial agreement and broken appointment policies. The patient and/or responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contracted agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be covered service by third party insurers or payors.

I agree that balances over 45 days be applied to my credit card and that I will be responsible for obtaining insurance reimbursement for any outstanding claims. This consent will remain in effect unless cancelled in writing.

Child (ren)'s name:____

Name of parent/guardian:____

Signature:_____________________________ Date:_______________________

Credit Card: MC VISA AMEX Discover #_______________ Exp:_______________

Office Witness Signature: _______________________ Date: _______________________