

Patient Information

11601 Robious Road, Suite 130 • Midlothian, VA 23113
(804) 794-3498

Date _____

Child's Information

Child's Name _____

Birthdate _____ Age _____ Male Female

Address _____

Names and ages of brothers and sisters _____

Physician or pediatrician _____

Phone _____

Who accompanied the child today?

Name _____

Relationship to child _____

Do you have legal custody of this child? yes no

Parents' Information

Mother's name _____

Address _____

Home phone _____

SS# _____

Employer _____

Work phone _____

Cell phone _____

E-mail address _____

Father's name _____

Address _____

Home phone _____

SS# _____

Employer _____

Work phone _____

Cell phone _____

E-mail address _____

Parents' marital status: single married

divorced widowed separated

Primary Dental Information

In order for our office to file your dental insurance, this information must be completed or payment is due at time of treatment.

Insurance company name _____

Address _____

Phone _____

Group # _____

Insured's name _____

Date of birth _____

Relationship to child _____

SS# _____

Employer _____

Consent

I understand that because my child is a minor it is necessary that signed permission be obtained from a parent or guardian before any dental services may be performed for my child. I also understand that authorization from a parent or guardian is necessary to release medical information to my child's physician or pediatrician.

I certify that I am a parent or guardian of my child who is described in this Patient Information form. I hereby grant permission to Roger E. Wood, D.D.S., Nicholas C. Lombardoizzi, D.D.S., P.C., and its employees and agents to perform all reasonably necessary or recommended dental services for my child, regardless of whether I am present while such services are being rendered. I also authorize the release of medical information, if necessary, to my child's physician or pediatrician.

I hereby certify that the information I have given is correct and true to the best of my knowledge. Furthermore, I give permission for the release of any information to any and all physicians, institutions or agencies which may have an interest in the settlement of payments for services rendered. I further authorize direct payments to Roger E. Wood, D.D.S., Nicholas C.

Lombardoizzi, D.D.S., P.C., from the insurance company listed herein or subsequent insurance I may obtain. This contract or agreement shall be in full force and effective until revoked in writing by the undersigned.

I guarantee payment to Roger E. Wood, D.D.S., Nicholas C. Lombardoizzi, D.D.S., P.C., for all charges incurred by my child, including services not covered by insurance. Should the account fall into default status, (60 days past due), 1.5% interest on the outstanding principal balance may be assessed monthly, as well as a late fee of \$29.00 and a broken appointment fee of \$51.00 – if 24-hour notice is not given. If it becomes necessary to refer this account to an agency and/or attorney for collection, I agree to pay the principal amount due plus interest, all costs of collection, all court costs, and attorney's fee in an additional amount equal to 1/3 of the outstanding principal balance on this account.

Signed _____

Child's Dental History

- | | No | Yes | |
|--|--------------------------|--------------------------|-----------------------------------|
| 1. Is this your child's first visit to the dentist? | <input type="checkbox"/> | <input type="checkbox"/> | If no, date of last checkup _____ |
| 2. Has your child had a toothache recently? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, where _____ |
| 3. Has your child fallen and chipped or bumped any of his/her teeth? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, where _____ |
| 4. Has your child had any unfavorable experience in the dental office? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, explain _____ |
| 5. Has your child had a history of thumbsucking, lip or nail-biting? | <input type="checkbox"/> | <input type="checkbox"/> | If yes, how often? _____ |
| 6. Do you brush your child's teeth? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7. Does your child wear a mouth guard when playing sports? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 8. Person and phone number (other than parent) to contact in case of emergency _____ | | | |
| _____ | | | |
| 9. Whom may we thank for referring you to us? _____ | | | |
| _____ | | | |

Child's Medical History

- | | |
|--|---|
| 1. What type of water supply do you have?
<input type="checkbox"/> city/county <input type="checkbox"/> well <input type="checkbox"/> bottled water | 7. Has your child ever experienced any of the following? (please check all that apply): |
| 2. Does your child have any allergies? <input type="checkbox"/> no <input type="checkbox"/> yes
If yes, explain _____ | <input type="checkbox"/> ADHD/ADD |
| 3. Is your child taking any medication at this time? <input type="checkbox"/> no <input type="checkbox"/> yes
If yes, list _____ | <input type="checkbox"/> Anemia |
| 4. Is your child taking any vitamins at this time? <input type="checkbox"/> no <input type="checkbox"/> yes
If yes, list _____ | <input type="checkbox"/> Asthma/asthma-like symptoms |
| 5. Has your child had any unfavorable reaction or allergy to medication, such as penicillin, aspirin, local anesthetic or latex? <input type="checkbox"/> no <input type="checkbox"/> yes
If yes, explain _____ | <input type="checkbox"/> Autism or Autistic Spectrum |
| 6. Has your child ever been hospitalized? <input type="checkbox"/> no <input type="checkbox"/> yes
If yes, explain _____ | <input type="checkbox"/> Bleeding disorders |
| Date of last physical _____ | <input type="checkbox"/> Blood transfusion |
| | <input type="checkbox"/> Bronchitis |
| | <input type="checkbox"/> Cerebral palsy |
| | <input type="checkbox"/> Congenital heart disease/surgery |
| | <input type="checkbox"/> Convulsions/seizures |
| | <input type="checkbox"/> Developmental delays |
| | <input type="checkbox"/> Diabetes |
| | <input type="checkbox"/> Diagnosed with congenital syndrome |
| | <input type="checkbox"/> Epilepsy |
| | <input type="checkbox"/> Hepatitis |
| | <input type="checkbox"/> HIV positive |
| | <input type="checkbox"/> Kidney or liver disease |
| | <input type="checkbox"/> Malignant hyperthermia (family history) |
| | <input type="checkbox"/> Medications to help in school |
| | <input type="checkbox"/> MRSA |
| | <input type="checkbox"/> Pneumonia |
| | <input type="checkbox"/> Rheumatic or scarlet fever |
| | <input type="checkbox"/> Seizures |
| | <input type="checkbox"/> Sleep apnea |
| | <input type="checkbox"/> Other medical problems _____ |