

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: \_\_\_\_\_ Birth date: \_\_\_\_\_ 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 the 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 1<sup>st</sup> 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*)

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

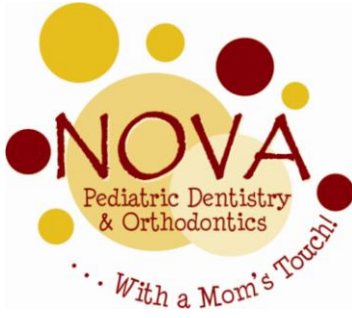
**Reviewed by: Doctor** \_\_\_\_\_ **Date:** \_\_\_\_\_

**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: \_\_\_\_\_