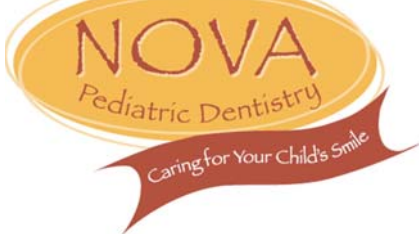


Valerie V. Woo, DMD, PC



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

Patient Name

Date of Birth:

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): _____

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/How did you hear about us? _____

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. Why is your child here today? _____
2. If your child has been to a dentist previously:
When was last visit? _____ Have X-rays been taken? Yes No When: _____
3. How did your child react? _____
4. Has your child had local anesthetic ("Novocaine"?) Yes No
Were there any problems? _____
5. **Fluoride:** Has your child had fluoride in any of the following forms:
Fluoride tablets or fluoride multivitamins..... 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
Do you or your child use dental floss in cleaning their teeth?..... Yes No
What kind of toothbrush does he or she use? Hard Soft Battery
7. **Diet:** Does your child snack frequently?..... Yes No
If yes, what do those snacks usually consist of? _____
How much soda and juice does your child usually drink per day? _____
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..... Yes No
Pacifier sucking..... 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. Were 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*)

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