

thank you for choosing Vienna Pediatric Dentistry.

Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely.

Your Child

Child's Name _____ Sex _____ Age _____
Nickname _____ Birthdate _____
School _____ Grade _____
Child's Home Address _____
City _____ State _____ Zip _____ Phone _____
Whom should we thank for the referral _____

Parent or Guardian Information

Mother

Stepmother

Guardian

Name _____ Birthdate _____ Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ Occupation _____
SS# _____ DL # _____
Marital Status Single Married Separated Divorced Widowed

Parent or Guardian Information

Father

Stepfather

Guardian

Name _____ Birthdate _____ Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ Occupation _____
SS# _____ DL # _____
Marital Status Single Married Separated Divorced Widowed

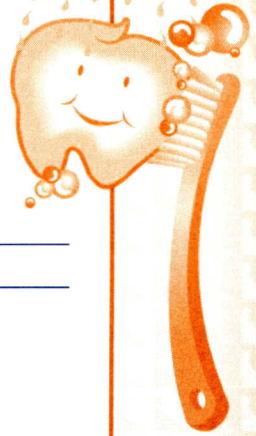
Primary Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS# _____
Employer _____ Occupation _____
Insurance Co. _____ Group # _____ ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS# _____
Employer _____ Occupation _____
Insurance Co. _____ Group # _____ ID # _____
Ins. Co. Address _____ City _____ State _____ Zip _____
Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Over Please



Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/Finger Yes No

Suck/Bite Lip Yes No

Bite/Chew Nails Yes No

Chew Hard Objects (pencils, etc.) Yes No

Grind Teeth Yes No

Clench Jaws Yes No

Date of Last Dental Visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits? Yes No

Is your child allergic to or had any reaction to any of the following:

Local Anesthetic Yes No

Penicillin Yes No

Amoxicillin Yes No

Other Antibiotics Yes No

Sulfa Drugs Yes No

Latex Yes No

Any Metals Yes No

Environmental Yes No

Other _____

Has your child ever had any of the following:

Asthma Yes No

Handicaps/Disabilities Yes No

Cancer Yes No

Tuberculosis Yes No

Hepatitis Yes No

Diabetes Yes No

HIV/AIDS Yes No

Rheumatic Fever Yes No

Hemophilia Yes No

Congenital Heart Defect Yes No

Abnormal Bleeding Yes No

Heart Murmur Yes No

Stomach, Liver or Kidney Problems Yes No

Convulsions/Epilepsy Yes No

Autism Yes No

Hay Fever/Allergies Yes No

Leukemia Yes No

ADD/ADHD Yes No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses _____ When? _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? Yes No

(if yes, please describe) _____

Please explain any medical problems that your child has: _____

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent/Guardian if minor)

Date