Capitol Hill
pediatric dentistry

WELCOME

CHILD'S INFORMATION			
CHILD'S NAME:		NICKNAME:	
DATE OF BIRTH:	SEX:	CELL PHONE:	
ADDRESS:	CITY:	STATE:	ZIP:
PARENT OR GUARDIAN NAME:			
SCHOOL:		GRADE:	
SIBLINGS (NAMES & AGES):			
WHOM MAY WE THANK FOR REFERRING YOU TO OUR PRACTICE?			

PARENTS' (INSURANCE SUBSCRIBER) INFORMATION:		
SUBSCRIBER NAME:		BIRTHDATE:
ADDRESS:		
HOME NUMBER:	WORK NUMBER:	CELL NUMBER:
EMPLOYER:		OCCUPATION:
EMAIL:		
DENTAL INSURANCE:		DENTAL INSURANCE TELEPHONE NUMBER:
SUBSCRIBER ID NUMBER:		SUBSCRIBER GROUP:

CHILD'S MEDICAL HISTORY:

CHILD'S PHYSICIAN: DATE OF LAST VISIT:

NAME OF PRACTICE: PHONE NUMBER:

ARE IMMUNIZATIONS CURRENT? YES NO

IS YOUR CHILD UNDER MEDICAL CARE AT PRESENT? YES NO IF YES, PLEASE EXPLAIN:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING DISEASES OR CONDITIONS? PLEASE CHECK OFF ALL THAT APPLY:

ADD/ADHD	CHRONIC SINUS INFECTIONS	HEART DISEASE	RHEUMATIC FEVER
ALLERGIES	CHRONIC EAR INFECTIONS	HEART MURMUR	SICKLE CELL DISEASE
ANEMIA	CYSTIC FIBROSIS	HEART DEFECTS	SICKLE CELL TRAIT
ANXIETY/DEPRESSION	SEIZURES/EPILEPSY	HEMOPHILIA	TUBERCULOSIS
ASTHMA	DEVELOPMENTAL DELAY	KIDNEY PROBLEMS	NEUROLOGICAL PROBLEMS
AUTISM/ASPERGER	DIABETES	LIVER PROBLEMS	ORTHOPEDIC PROBLEMS
BLEEDING DISORDERS	DOWN SYNDROME	LUNG PROBLEMS	EYE PROBLEMS
CANCERS	HIV/AIDS	PSYCHIATRIC TREATMENTS	ACID REFLUX
CEREBRAL PALSY	HEPATITIS	SPEECH/HEARING PROBLEMS	
CLEFT LIP/PALATE	EMOTIONAL DISTURBANCES	BIRTH DEFECTS	
HIGH BLOOD PRESSURE	LEARNING DISABILITIES	PREMATURE BIRTH	

DOES YOUR CHILD HAVE ANY OTHER DISEASES, CONDITIONS, OR SYNDROMES NOT LISTED ABOVE? YES NO

IF YES, PLEASE EXPLAIN:

IS YOUR CHILD ALLERGIC TO ANY FOOD OR MEDICINE? YES NO

IF YES, PLEASE LIST:

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATIONS? YES NO

IF YES, PLEASE LIST:

HAS YOUR CHILD EVER BEEN SEDATED OR HAD GENERAL ANESTHESIA? YES NO

IF YES, WHAT FOR?

HAS YOUR CHILD EVER HAD SURGERY OR BEEN HOSPITALIZED? YES NO

IF YES, PLEASE EXPLAIN:

http://capitolhillpediatric.dentist/
202-849-3292 (office) 866-727-8958 (Fax)
Capitol Hill, Washington DC

IS YOUR CHILD HAVING ANY DIFFICULTIES IN SCHOOL? YES NO

IF YES, PLEASE EXPLAIN:

IS THERE ANYTHING ELSE WE SHOULD KNOW ABOUT YOUR CHILD?

IS THERE ANYTHING ABOUT YOUR CHILD YOU WOULD LIKE TO DISCUSS IN PRIVATE? YES NO

DENTAL HISTORY:

PLEASE CHECK OFF REASON(S) FOR SEEKING DENTAL CARE:

FIRST EXAMINATION ROUTINE CHECK-UP TOOTHACHE OR SWELLING CAVITIES

APPEARANCE OF TEETH CROWDING ACCIDENT/INJURY

OTHER:

HAS YOUR CHILD BEEN TO A DENTIST PREVIOUSLY? YES NO WHEN: WHERE:

WERE X-RAYS TAKEN: YES NO NOT SURE

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS?

THUMB/FINGER SUCKING MOUTH BREATHING PACIFIER SNORING

BOTTLE/SIPPY CUP LIP SUCKING/BITING GRINDING/CLENCHING

WHAT SOURCE OF WATER DOES YOUR CHILD DRINK: CITY WATER BOTTLED WATER WELL WATER

IS YOUR CHILD BREAST FED OR USING A BOTTLE/SIPPY CUP? YES NO IF NO, WHAT AGE DID IT STOP?

FREQUENCY OF TOOTH BRUSHING? **FLOSSING?**

WHO DOES THE BRUSHING? (CHECK ALL THAT APPLY) CHILD PARENT/GUARDIAN

WHAT TYPE OF TOOTHPASTE DOES YOUR CHILD USE: FLUORIDE NO FLUORIDE

HAS YOUR CHILD EVER EXPERIENCED ANY PROBLEMS OR COMPLICATIONS DUE TO DENTAL CARE? YES NO

IF YES, PLEASE EXPLAIN:

CONSENT:

THE INFORMATION I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY CHILD'S MEDICAL STATUS. I AUTHORIZE THE CAPITOL HILL PEDIATRIC DENTISTRY TEAM TO COMPLETE **A DENTAL EVALUATION, INCLUDING EXAMINATION, X-RAYS, PHOTOGRAPHS, CLEANING AND FLUORIDE TREATMENT** WHEN NECESSARY AS STANDARD OF CARE TO PROPERLY DIAGNOSE AND RECORD ANY AND ALL DENTAL CONDITIONS. **(PLEASE CROSS OUT ANY TREATMENT THAT YOU DO NOT WANT PERFORMED.)** I AUTHORIZE MY INSURANCE COMPANY TO PAY CAPITOL HILL PEDIATRIC DENTISTRY ALL INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I ALSO AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES FOR SERVICES RENDERED WHETHER OR NOT IT IS COVERED BY MY INSURANCE, INCLUDING ALL LATE PAYMENT SERVICES CHARGES. THIS CONSENT IS TO REMAIN IN EFFECT FROM THE DATE INDICATED UNTIL CANCELLED IN WRITING.

AUTHORIZED SIGNATURE RELATIONSHIP TO CHILD DATE

OFFICE USE ONLY

SBE PROPHYLAXIS REQUIRED: YES NO **PRECAUTIONS:**

SUMMARY:

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