Capitol Hill
pediatric dentistry

WELCOME

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

PARENTS'/LEGAL GUARDIAN 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. _____

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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