RICHMOND VIRGINIA Pediatric Dentistry

Dr. Shreya Desai, DDS, MS
Pediatric Dentist

Getting to Know Your Child

Date: _____

Child's Name: _____ Date of Birth: _____

Preferred Name: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Gender: ❑ M ❑ F ❑ Other _____

Name of School: _____ Grade: _____

Child's Hobbies and Interests: _____

Sibling Name(s) and Age(s): _____

Who has legal custody of this child?: _____

Parent/Guardian Contact Info

Parent (Guardian) #1 Name: _____ Relationship to Patient: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Date of Birth: _____ Employer/Occupation: _____

Parent (Guardian) #2 Name: _____ Relationship to Patient: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Phone: _____

Date of Birth: _____ Employer/Occupation: _____

How did you hear about us? _____

What is the purpose of today's visit? _____

Medical History

Insurance Provider: _____ Subscriber Name: _____

Policy Number: _____ Group Number: _____ SSN of Responsible Party: _____

Pediatrician's Name: _____ Date Of Last Medical Exam: _____

Pediatrician's Phone: _____

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DOES YOUR CHILD HAVE (OR HAS HAD) ANY OF THE FOLLOWING CONDITIONS?

Y	N		Y	N		Y	N	
○	○	Traumatic injury to mouth or teeth	○	○	Developmental Delay	○	○	Pneumonia
○	○	ADHD/ADD	○	○	Diabetes	○	○	Premature Birth _____ weeks
○	○	AIDS-HIV+	○	○	Down Syndrome	○	○	Pulmonary Disease
○	○	Allergy to Latex, Metals, or Acrylics	○	○	Emotional Difficulties/Psychiatric Care	○	○	Sleep Apnea
○	○	Allergy to Penicillin	○	○	Epilepsy, Seizures, Convulsions	○	○	Speech/Hearing Difficulty
○	○	Allergy to Other Drugs _____	○	○	Extreme Nervousness/Apprehension	○	○	Syndrome _____
○	○	Anemia	○	○	Hay Fever, Sinus Problems	○	○	Thyroid Disorder
○	○	Asthma	○	○	Heart Murmur, Defect, or Surgery	○	○	Tonsillitis
○	○	Autism	○	○	Hemophilia	○	○	Tuberculosis
○	○	Birth Defects	○	○	Hepatitis A, B, C	○	○	Ulcers, Crohn's Disease, Colitis
○	○	Blood Transfusion	○	○	History of Child Abuse	○	○	Visual Impairment
○	○	Cancer (Chemo/Radiation)	○	○	Kidney Disease			
○	○	Cerebral Palsy	○	○	Liver Disease			

Does your child have any other conditions not listed above?: ❑ No If yes, please explain: _____

_____

Does your child have any other allergies not listed above?: ❑ No If yes, please explain: _____

Medications: ❑ No If yes, please explain: _____

Hospitalizations: ❑ No If yes, please explain (Age/Reason): _____

_____

Dental History

Name of Previous Dental office/Dentist's name: _____

Date of Last Dental Exam: _____ Any unfavorable dental experiences?: ❑ No If yes, please explain: _____

DOES YOUR CHILD HAVE (OR USE) ANY OF THE FOLLOWING?

Y	N		Y	N		Y	N	
○	○	Traumatic injury to mouth or teeth	○	○	Teeth sensitivity to cold/heat/sweets/pressure	○	○	Brushing – frequency? _____
○	○	Bleeding gums – how long? _____	○	○	Pain around ears	○	○	Dental floss
○	○	Clenching or grinding of teeth	○	○	Bad breath	○	○	City or well water _____
○	○	Swellings or lumps in mouth	○	○	Orthodontic treatment	○	○	Fluoride mouthwash
○	○	Frequent blisters on lips or in mouth	○	○	Mouth breathing	○	○	Fluoride supplements
○	○	Drinks other than water beyond meals (bottle of milk to bed)	○	○	Oral habits – thumb sucking, fingernail biting, cheek biting, etc.	○	○	Snacks between meals
						○	○	Well balanced diet

To avoid misunderstandings regarding dental insurance, we ask the responsible party to know that all professional services rendered are charged to them and that they are personally responsible for payment fees. Any questions concerning insurance benefits should be directed to the insurance company's representative or benefits office. The deductible and or co-payment is expected at time of service. We do not render our services on the basis that insurance companies will pay all fees. I have read the above statement and accept the terms and conditions. To the best of my knowledge, the questions on this form have been accurately answered. I hereby authorize payment of dental benefits otherwise be payable directly to RVO Pediatric Dentistry.

Parent/Guardian Signature: _____ **Date:** _____