

Q Smiles Dental

www.qsmilesdentalpc.com

7815 Sudley Road

Manassas, VA 20109

Tel.: (571) 208-1325

Fax: (571) 208-1326

Email: qsmilesdentalpc@gmail.com

Child's Registration and Medical History

Your child's complete oral health is our main concern. Communication is key to helping us give your child a happy, healthy smile. We therefore ask that you complete this form in its entirety.

1 ABOUT CHILD

Today's Date: _____

Name: _____

Nickname: _____ LAST FIRST MI ☐ Male ☐ Female

Birthdate: ____/____/____ Age: _____ SS #: _____

Home Address: _____

_____ APT / CONDO #

_____ CITY STATE ZIP

Home #: () Cell #: ()

Where and when are best times to reach you? _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

2 PARENT INFORMATION

Father's Name: _____

Birthdate: ____/____/____ Age: _____ SS #: _____

Employer: _____

Home #: () Cell #: ()

Work #: () Ext: _____ DL #: _____

Mother's Name: _____

Birthdate: ____/____/____ Age: _____ SS #: _____

Employer: _____

Home #: () Cell #: ()

Work #: () Ext: _____ DL #: _____

Person Responsible for Account:

Work #: () Ext: _____ Home #: ()

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ()

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: ()

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

In the event of an emergency, who should
be notified, other than a parent?

Name: _____ Relation: _____

Address: _____

Work #: () Home #: ()

4 MEDICAL HISTORY

Does your child have a personal physician?..... ☐ Yes ☐ No

Physician's Name: _____

Phone #: () Date of last visit: _____

Is the child currently under the care of a physician?..... ☐ Yes ☐ No

Please Explain: _____

4

MEDICAL HISTORY *continued*

Date of last physical: _____

Child's current physical health is: _____ ☐ Good ☐ Fair ☐ Poor

Is child taking any prescription, over-the-counter, or supplement drugs? ☐ Yes ☐ No

Please list each one: _____

Does your child smoke or use tobacco in any other form? ☐ Yes ☐ No

Has your child ever had any of the following diseases or medical problems? (Please check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Aids or Other | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Immunosuppressive Disorders | <input type="checkbox"/> Hearing Problems |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Allergies to Medicines or Drugs | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis, Jaundice, or Liver Disease |
| <input type="checkbox"/> Artificial Heart Valves or Joints | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |

Please list any serious medical condition(s) that your child has had: _____

Is your child allergic to any of the following?

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Jewelry/Metals | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> Other |

Please list any other drugs/materials that child is allergic to: _____

We appreciate your effort to fill out this complete form. It will ensure that we can provide the most effective care possible. Please do not hesitate to ask if you have any questions. We are here for you.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

5

DENTAL HISTORY

Why have you come to the dentist today?

When was child's last dental visit? _____

Experiencing any discomfort now? _____

Do you desire complete dental service for your child? _____

Has your child ever responded adversely to medical or dental treatment? _____

Has your child ever been on or has any physician ever told you your child needs to have premedication before dental work? ☐ Yes ☐ No

Is there anything else we should know about child's dental history? _____

How many times a week does child floss? _____

How many times a day does child brush? _____

Type of bristles? ☐ Hard ☐ Medium ☐ Soft

I understand the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

Relationship to child _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

2. Date: _____ Comments: _____ Signature: _____

3. Date: _____ Comments: _____ Signature: _____