

# Patient Medical History

Sparkle Pediatric Dentistry  
8203 Center Path Lane, Suite A  
Mechanicsville, Virginia 23116

804-746-7382  
Office Phone Number  
www.sparklepediatricdentistry.com

Sparkle Pediatric Dentistry  
11934 W. Broad Street, Suite 120  
Henrico, Virginia 23233

**Patient Information** — We welcome you into our practice, and we will try to make your dental experience very pleasant. Please complete this for thoroughly because this information is of great value in helping us to better understand and care for you.

Patient Name \_\_\_\_\_ Nickname \_\_\_\_\_ Appointment Date \_\_\_\_\_

□ Male □ Female LAST FIRST MI Siblings & Ages \_\_\_\_\_

Email Address \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Primary Phone ( ) \_\_\_\_\_ School \_\_\_\_\_ Grade \_\_\_\_\_ Weight \_\_\_\_\_

Address \_\_\_\_\_

STREET

APT NO.

CITY

STATE

ZIP

**Health Information** — Has the patient ever had any of the following? Please check those that apply.

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> AIDS                              | <input type="checkbox"/> Cerebral Palsy           | <input type="checkbox"/> Kidney Problems      | <input type="checkbox"/> Rheumatic Fever  |
| <input type="checkbox"/> Allergies: Drug or Latex<br>_____ | <input type="checkbox"/> Chicken Pox              | <input type="checkbox"/> Liver Problems       | <input type="checkbox"/> Sinus Problems   |
| <input type="checkbox"/> Anemia                            | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Lung Problems        | <input type="checkbox"/> Speech Problems  |
| <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Emotional Disorder       | <input type="checkbox"/> Medications          | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Behavioral Problems               | <input type="checkbox"/> Epilepsy                 | _____   | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> ADHD □ Autism                     | <input type="checkbox"/> Hearing Problems         | <input type="checkbox"/> Mental Retardation   | <input type="checkbox"/> Vision Problems  |
| <input type="checkbox"/> Bleeding Disorders                | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Mononucleosis        | <input type="checkbox"/> Other _____      |
| <input type="checkbox"/> Blood Transfusion                 | <input type="checkbox"/> Heart Conditions         | <input type="checkbox"/> Mumps/Measles        | _____                                     |
| <input type="checkbox"/> Cancer                            | <input type="checkbox"/> Hospitalization          | <input type="checkbox"/> Pregnancy            | _____                                     |
|  | <input type="checkbox"/> Immunizations up-to-date | <input type="checkbox"/> Respiratory Problems |   |

Pediatrician/PCP Name \_\_\_\_\_ Last Visit \_\_\_\_\_ Phone \_\_\_\_\_

Has the patient been seen by another dentist? □ No □ Yes, Name \_\_\_\_\_

Date of last visit \_\_\_\_\_ Phone \_\_\_\_\_

Has the patient had an unfavorable dental experience? \_\_\_\_\_

Does the patient have a past or current history thumb/finger sucking? □ Yes □ No Pacifier □ Yes □ No

Was the patient breast fed? □ Yes □ No Bottle Fed? □ Yes □ No Age discontinued? \_\_\_\_\_

What is your home water source? □ Public System □ Private Well □ Other \_\_\_\_\_

**Consent For Services** — As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends on the reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of patient examination.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in full force and effect until cancellation by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefit be denied.

**I have read the above conditions of treatment and agree to their content.**

\_\_\_\_\_  
Date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

SIGNATURE OF PARENT/GUARDIAN

## Guardian Information

Guardian Name \_\_\_\_\_  Married  Single

Social Security Number \_\_\_\_\_ LAST FIRST MI  
Birthdate \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Mobile ( ) \_\_\_\_\_

Address \_\_\_\_\_

STREET

APT NO.

CITY

STATE

ZIP

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer Address \_\_\_\_\_

Street

City

State

Zip

Guardian Name \_\_\_\_\_  Married  Single

Social Security Number \_\_\_\_\_ LAST FIRST MI  
Birthdate \_\_\_\_\_ Driver's License No. \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Work ( ) \_\_\_\_\_ Mobile ( ) \_\_\_\_\_

Address \_\_\_\_\_

STREET

APT NO.

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STATE

ZIP

Employer Name \_\_\_\_\_ Occupation \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer Address \_\_\_\_\_

Street

City

State

Zip

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## Emergency Information – Nearest relative not living in same household.

Name \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_

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## Primary Insurance Information

Name of Insured \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_ LAST FIRST MI  
ID No. \_\_\_\_\_ Group No. \_\_\_\_\_

Insured's Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Street

City

State

Zip

Patient's Relationship to Insured  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address \_\_\_\_\_

Insurance Company's Phone \_\_\_\_\_

*I hereby authorize payment of the dental benefits*

*otherwise payable to me, directly to Hanover Pediatric Dentistry*

Signature of Employee/Subscriber \_\_\_\_\_

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## Referral Information – Whom may we thank for referring you to our practice?

Another Patient (friend)  Another Patient (relative)  Dental Office  Yellow Pages  Newspaper  School  Work

Other \_\_\_\_\_ Name of person or office referring you to our practice? \_\_\_\_\_