Welcome!

Brown, Reynolds, Snow Dentistry, 6901 Patterson Avenue, Richmond, VA 23226, (804) 288-5324

Tell Us About Your Child

Today's Date: _____ Child's Home Phone #: (____)_____ Social Security #: _____

Child's Name: _____ (Last / First / MI) Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ❑ Male ❑ Female School: _____ Grade: _____

Child's Home Address: _____ (Street / City / State / Zip)

Whom may we thank for referring you? _____

Parent's Information

Parent's Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Remarried ❑ Single

Mother Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____) _____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____ (Street / City / State / Zip)

Employer: _____ Length of Employment: _____

Father Birthdate: ____/____/____ Home Phone #: (____)_____ Work Phone #: (____) _____

Name: _____ Social Security #: _____ Driver's License #: _____

Address: _____ (Street / City / State / Zip)

Employer: _____ Length of Employment: _____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____ (PO Box/Street / City / State / Zip)

Insured's Name: _____ Relationship to Patient: _____

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Employer's Address: _____ (Street / City / State / Zip)

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local, or Policy #): _____

Insurance Co. Address: _____ (PO Box/Street / City / State / Zip)

Insured's Name: _____ Relationship to Patient _____

Insured's Birthdate: ____/____/____ Social Security #: _____ Insured's Employer: _____

Employer's Address: _____ (Street / City / State / Zip)

CONTINUED ON BACK

Dental History

Is the child currently in pain? ❑ **Yes** ❑ **No** **What is the primary reason for today's visit?** _____

Has the child experienced problems with previous dental work? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No

Floss his / her teeth daily? ❑ Yes ❑ No

Previous / Present Dentist: _____ Date of Last Visit _____
(Please Circle)

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Does / did the child have any of the following habits?

- ❑ Lip Sucking / Biting
- ❑ Nail Biting
- ❑ Chewing on Objects
- ❑ Clenching / Grinding Teeth
- ❑ Thumb / Finger Sucking
- ❑ Nursing Bottle Habits
- ❑ Tongue / Cheek Biting
- ❑ Used Pacifier
- ❑ Tongue Thrust
- ❑ Mouth Breather
- ❑ Speech Problems
- ❑ Breast Fed

Medical History

Child's Physician: _____ Phone #: (____) _____ Date of last visit: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? ❑ Yes ❑ No Please explain: _____

Please describe the child's current physical health: ❑ Good ❑ Fair ❑ Poor **Are Immunizations Current?** ❑ Yes ❑ No

Please list all drugs that the child is currently taking: _____

Please list all drugs and/or things that cause the child allergic reactions:

Anything you would like to discuss with the Doctor in private? ❑ Yes ❑ No

Has the child had/experienced any of the following:

- ❑ Abnormal Bleeding
- ❑ AIDS / HIV+
- ❑ Allergies
- ❑ Anemia
- ❑ Any Hospital Stay / Operations
- ❑ Asthma
- ❑ Blood Transfusion
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Congenital Heart Defect
- ❑ Convulsions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Handicaps / Disabilities
- ❑ Hearing Impairment
- ❑ Heart Murmur
- ❑ Hemophilia
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Hives
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Low Blood Pressure
- ❑ Lupus
- ❑ Measles
- ❑ Mitral Valve Prolapse
- ❑ Mononucleosis
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sickle Cell Anemia
- ❑ Skin Rash
- ❑ Tonsillitis
- ❑ Tuberculosis (TB)

Please discuss any serious medical problems the child experiences/ed: _____

Authorization

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on friendly, mutual understanding between provider and patient. Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the financial manager. If account is not paid with in 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, interest charges and any other expenses incurred in collecting your account. I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims. I understand the above information and guarantee this form was completed to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____
Signature Date

