Richmond Pediatric Dentistry and Orthodontics

(804)741-2226

www.RPDO.com

2560 Gaskins Road, Richmond, VA 23238
7521 Right Flank Road, Suite 110, Mechanicsville, VA 23116

Carl O. Atkins, Jr., D.D.S.
Christopher L. Maestrello, D.D.S.
Elizabeth C. Miller, D.D.S.
Raymonia A. Eddleton, D.D.S.
Rebecca T. Wehman, D.D.S.
Reham M. AlNajjar, D.D.S.

CHILD'S INFORMATION AND HEALTH HISTORY

INITIAL EXAM **DATE**_____

CHILD'S FULL NAME_____DATE OF BIRTH_____
(Name Child Prefers)

CHILD'S ADDRESS_____HOME PHONE(____)_____

CITY_____ STATE_____ZIP CODE_____ **PREFERRED** PHONE(____)_____

HOBBIES AND INTERESTS_____ GENDER M / F

BROTHERS AND SISTERS NAMES_____

PARENT (Guardian) NAME _____ **Relation to Patient** _____

HOME ADDRESS_____

CITY_____ STATE_____ZIP CODE_____HOME PHONE(____)_____

DATE OF BIRTH_____**S.S#**_____CELL PHONE (____)_____

EMPLOYED BY_____DEPARTMENT_____

EMAIL ADDRESS_____BUSINESS PHONE(____)_____

PARENT (Guardian) NAME _____ **Relation to Patient** _____

HOME ADDRESS_____

CITY_____ STATE_____ZIP CODE_____HOME PHONE(____)_____

DATE OF BIRTH_____**S.S#**_____CELL PHONE (____)_____

EMPLOYED BY_____DEPARTMENT_____

EMAIL ADDRESS_____BUSINESS PHONE(____)_____

NAME OF FRIEND OR NEIGHBOR WHO CAN REACH YOU IN CASE OF EMERGENCY_____

HOME NUMBER (____)_____ CELL PHONE (____)_____

DENTAL INSURANCE PLAN (IF ANY)_____SUBSCRIBER NAME_____

POLICY#_____GROUP#_____

HOW DID YOU HEAR ABOUT US?

☐ Pediatrician_____ ☐ Insurance Carrier ☐ Family/Friend _____
☐ Dentist_____ ☐ Advertisement ☐ Website _____
☐ Health Department_____ ☐ Internet ☐ Other_____

Welcome! Please take a few moments to tell us a little about your child so that we may assist you in taking the very best care possible of him/her!

HEALTH HISTORY

PHYSICIAN'S NAME_____DATE OF LAST MEDICAL EXAM_____CHILD'S AGE_____

PHYSICIAN'S PHONE NUMBER(____)_____

YES	NO		YES	NO		YES	NO	
◯	◯	Allergy to Penicillin	◯	◯	Blood Transfusion	◯	◯	Kidney Problems
◯	◯	Allergies to Other Drugs	◯	◯	Cancer	◯	◯	Leukemia
◯	◯	Allergies to Local Anesthetics	◯	◯	Cerebral Palsy	◯	◯	Liver Problems, Hepatitis
◯	◯	Allergies to Latex, Metals or Acrylics	◯	◯	Chemotherapy / Radiation	◯	◯	Mental or Physical Handicap
◯	◯	Heart Murmur, Defect or Surgery	◯	◯	Child Abuse	◯	◯	Premature Birth
◯	◯	AIDS - HIV	◯	◯	Developmentally Delayed	◯	◯	Rheumatic Fever
◯	◯	Anemia or Blood Problems	◯	◯	Emotional Difficulties / Psychiatric Care	◯	◯	Sickle Cell Anemia
◯	◯	Asthma	◯	◯	Extreme Nervousness or Apprehension	◯	◯	Syndrome_____
◯	◯	Diabetes	◯	◯	Eye Problems	◯	◯	Thyroid disorders
◯	◯	Epilepsy, Seizures, Convulsions	◯	◯	Hay Fever, Sinus Problems, General Allergies	◯	◯	Tonsilitis
◯	◯	Autism	◯	◯	Hearing / Speech Problems	◯	◯	Tuberculosis
◯	◯	Birth defects	◯	◯	Hyperactivity (ADD/ADHD)	◯	◯	Ulcer or colitis
◯	◯	Bleeding problems : Hemophilia				◯	◯	Other_____

Medications_____

Hospitalizations: Age and Reason_____

DENTAL HISTORY

DOES YOUR CHILD HAVE ANY DENTAL PROBLEMS AT THIS TIME?_____

DATE OF LAST DENTAL EXAM_____ANY UNFAVORABLE DENTAL EXPERIENCE, ◯ YES ◯ NO

PLEASE EXPLAIN_____

DOES THE CHILD HAVE OR USE ANY OF THE FOLLOWING - INDICATE WITH A (√)

◯Traumatic injury to mouth or teeth
◯Bleeding gums, How long_____
◯Clenching or grinding of teeth
◯Swelling or lumps in mouth
◯Frequent blisters on lips or mouth
◯Teeth sensitive to cold, heat, sweets or pressure
◯Pain around ear
◯Bad breath
◯Orthodontic treatment
◯Mouth breathing
◯Oral habits; thumbsucking, fingernail biting, cheek biting, etc.
◯Frequency of brushing by child_____/day
◯Frequency of brushing by parent_____/day
◯Dental floss
◯Fluoride supplements
◯Between meal snacks
◯Well balanced diet

APPOINTMENTS: Please realize we have reserved time especially for your child. If for some reason you must cancel your child's appointment we expect 48 hours notice (weekends not included). A charge will be made for failed or cancelled appointments without 48 hours (weekends not included) notice. This fee covers only a portion of the expense associated with the time reserved for your child. Failure to comply with this policy may result in the dismissal of your family from the practice.

INSURANCE: To avoid misunderstandings regarding dental insurance, we wish the persons responsible to know that all professional services rendered are charged to them and that they are personally responsible for payment of fees. As a courtesy to you we will prepare necessary forms or reports to help the persons responsible obtain benefits from insurance companies. 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 the time of service. We do not render our services on the basis that insurance companies will pay all our fees. Each fee is individual for the individual patient.

ACCOUNTS: All services are performed on the assumption that payment is expected at time of service. All account balances unpaid past 30 days will be credited with a monthly handling charge of 2% (annual percentage rate of 24%). In case it becomes necessary to seek collection resources due to default or late payment, all reasonable attorney's fees and other costs of collection will be in addition to the existing account balance.

CONSENT: Carl O. Atkins, Jr. D.D.S., Christopher L. Maestrello, D.D.S., Elizabeth C. Miller, D.D.S., Raymonia A. Eddleton, D.D.S., Rebecca T . Wehman, D.D.S., Reham M. AlNajjar, D.D.S., their associates and/or their staff are authorized to perform such dental and related surgical or medical treatments as deemed necessary and all risks and treatments will be explained as needed.

I have read the above and to the best of my knowledge the information is correct.

I have reviewed the treatment plan and fees. I Agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to my child's treatment.

I Hereby authorize payment of the dental benefits otherwise payable directly to Richmond Pediatric Dentistry and Orthodontics.

SIGNATURE_____DATE_____
PARENT OR GUARDIAN