HANOVER
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Mechanicsville, VA 23116

Sparkle
PEDIATRIC DENTISTRY
www.sparklepediatricdentistry.com • 804-746-7382

SHORT PUMP:
11934 W Broad St, Suite 120
Henrico, VA 23233

Patient Medical History

Patient Information

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

Patient Name ______________________ (LAST, FIRST, MI) Nickname __________ Appointment Date __________

□ Male □ Female 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.

□ AIDS	□ Cerebral Palsy	□ Kidney Problems	□ Rheumatic Fever
□ Allergies: Drug or Latex	□ Chicken Pox	□ Liver Problems	□ Sinus Problems
__________	□ Diabetes	□ Lung Problems	□ Speech Problems
□ Anemia	□ Emotional Disorder	□ Medications	□ Thyroid Disorder
□ Asthma	□ Epilepsy	__________	□ Tuberculosis
□ Behavioral Problems	□ Hearing Problems	□ Mental Retardation	□ Vision Problems
□ ADHD □ Autism	□ Hepatitis	□ Mononucleosis	□ Other __________
□ Bleeding Disorders	□ Heart Conditions	□ Mumps/Measles	__________
□ Blood Transfusion	□ Hospitalization	□ Pregnancy	__________
□ Cancer	□ Immunizations up-to-date	□ 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 breastfed? □ 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 therto. 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

Patient Medical History – 2

Guardian Information

Guardian Name ______________________________________ ☐ Married ☐ Single
LAST FIRST MI

Social Security Number ____________ 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
LAST FIRST MI

Social Security Number ____________ 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

Emergency Information – Nearest relative not living in same household.

Name ______________________________ Phone ( ) ____________

Address ____

Primary Insurance Information

Name of Insured ____
LAST FIRST MI

Insured's Birthdate ____________ 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 ____________

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? ____________