FREDERICK
PEDIATRIC DENTISTRY

Welcome to our Practice!

Dr. Michael T. Virts and Associated Specialists in Pediatric Dentistry

Frederick: 77 Thomas Johnson Drive, Suite A, Frederick, MD 21702
Hagerstown: 1150 Omega Drive, Suite 102, Hagerstown, MD 21740

Today's Date: _____

How did you learn about our practice? (circle all that apply)

Social Media Google Search Insurance List Word of Mouth

Referred by Physician/PA/NP/IBCLC Referred by Dentist Other (list below)

_____

_____

Please tell us about your child:

Child's Name: _____

Nickname: _____ Gender: _____ _____

Child's Birthdate: _____ Age: _____

Child's Primary Phone: _____

Child's Home Address: _____

City: _____ State: _____ Zip: _____

Child's Social Security Number: _____

School/Grade (if applicable): _____

Name(s) of Siblings: _____

Who is accompanying your child today?

Name: _____

Relation: _____

Do you have legal custody of the child? ☐ Yes ☐ No

If "no," please indicate the following information regarding the individual who <u>has</u> custody:

Name: _____

Relation: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Dental Insurance:

Name of Policyholder: _____ DOB: _____

Relation to Patient: _____

Insurance Company: _____

Address: _____

Plan Number: _____ Group Number: _____

Phone Number: _____

Parent/Guardian Information:

Marital Status: _____

<u>Parent/Legal Guardian #1</u>

Name:_____

DOB: _____

Social Security #: _____

Address: (Same as Child), or:

_____

City: _____ State: _____ Zip: _____

Primary Phone #: _____

Employer: _____ Work Phone: _____

E-Mail: _____

<u>Parent/Legal Guardian #2</u>

Name: _____

DOB: _____

Social Security #: _____

Address: (Same as Child), or:

_____

City: _____ State: _____ Zip: _____

Primary Phone Number: _____

Employer: _____ Work Phone: _____

E-Mail: _____

Person Responsible for Account:

☐ Same as above information (☐ P/LG #1 ☐ P/LG #2)

Or Other:

Name: _____

DOB: _____ Social Security #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

E-mail Address: _____

Medical Information:

Name of Child's Physician: _____ **Phone Number of Physician:** _____

Does your child see another physician (other than their primary care provider) for any specialized medical conditions? If so, please list their name and phone number. ☐ Yes ☐ No _____

Are your child's immunizations current? ☐ Yes ☐ No

Please list all medications, including vitamins and herbal supplements, that your child is currently taking or has been prescribed to take regularly: _____
_____

Has your child ever been hospitalized? (if yes, please list reason and date) ☐ Yes ☐ No _____

Does your child receive professional therapy services? ☐ Yes ☐ No
If so, what type of therapy is your child enrolled in? (Circle as needed): Occupational Physical Speech Emotional Behavioral

Does your child need to be premedicated before dental treatment due to a heart condition or other medical condition? ☐ Yes ☐ No

Please list all allergies your child has (including seasonal, food, and/or medication allergies): _____
_____

Please place a check next to (or circle) any of the medical conditions your child has experienced, been diagnosed with, and/or is suspected of having:

ADD/ADHD	Depression	Heart Murmur requiring medical care	Oppositional Defiant Disorder
Adenoid Removal	Developmental Delays	Heart Surgery	Orthopedic Surgery
Anemia	Diabetes	Hepatitis	PANDAS
Anxiety	Down Syndrome	High Blood Pressure	Penicillin Allergy
Asthma	Ear Tubes	Juvenile Arthritis	POTS
Autism Spectrum	Epilepsy	Kidney Disease	Pregnancy
Blood Disease	Gastrointestinal Surgery	Liver Disease	Seasonal/Environmental Allergies
Cancer	Genetic Disorder(s)	Medication Allergies	Seizure Disorder/Epilepsy
Cardiac Surgery	GERD/Acid Reflux	Migraines	Sinus Problems
Cerebral Palsy	Head Injuries /Concussion	Nutritional/Feeding Concerns	Tonsillectomy
Codeine Allergy	Heart Disease/Condition(s)	Obsessive-Compulsive Disorder	Tourette Syndrome

Please describe any medical or emotional condition your child has that is not listed above, or requires additional information:

_____

Pediatric Dental Information:

What brings you to see us today? _____ Is your child currently in pain? ☐ Yes ☐ No

Name of Previous Dentist: _____ Location of Previous Dentist: _____ Date of Last Dental Visit: _____

How often does your child brush his/her teeth? _____ How often does your child floss his/her teeth? _____

Is your child's drinking water fluoridated? ☐ Yes ☐ No Does your child take fluoride supplements? ☐ Yes ☐ No

Has your child ever had dental x-rays? ☐ Yes ☐ No If "yes," approximate date of last x-rays: _____
Has your child ever had an unpleasant experience with a dentist? ☐ Yes ☐ No If "yes," please briefly describe: _____
Has your child ever received local anesthesia (numbing) for dental treatment? ☐ Yes ☐ No

Please circle any habits your child currently has:

Chewing on Objects/Toys (past age 3)	Nail Biting	Tongue/Cheek Biting	Bottle feeding past age 2	Lip Sucking/Biting	Speech Problems
Clenching Teeth	Pacifier past 12 months of age	Mouth Breathing	Thumb/Finger Sucking	Tongue Thrust while swallowing	Grinding Teeth

The information I have provided in this form is true to the best of my knowledge. I understand that giving inaccurate information regarding the medical status of my child may be harmful to their health. I authorize Frederick Pediatric Dentistry, LLC to perform the recommended dental treatment for my child.

Parent/Guardian Signature: _____ **Printed Name:** _____ **Date:** _____

DDS/RDH Signature : _____ **Date:** _____