HARRISONBURG
PEDIATRIC DENTISTRY

INITIAL CONTACT

Date _____ Contact Name _____ Relationship _____

Child's Name _____ Male Female DOB _____

Address _____ Phone _____

Referred by _____ Last X-Rays/P&F _____

First Visit ____ Toothache ____ Insurance ____ Medicaid ____

CC _____

_____

Date Appointed _____

PATIENT INFORMATION

Preferred Name _____ Age _____

Interests _____ School _____ Grade _____

Whom does the child live with? _____ Who has legal custody? _____

Sibling names and ages _____

Name and number of emergency contact _____

DENTAL HISTORY

Previous Dentist _____ Date of last visit _____

Age of first dental visit _____

How do you expect your child to react to this appointment? _____

What is the reason for today's visit? _____

_____

Does your child have any of the following?

YES NO Current or past cavities
YES NO Family history of cavities
YES NO Bleeding gums
YES NO Toothache
YES NO Injury to the teeth, mouth or jaws
YES NO Sucking habit after one year of age
YES NO Medical condition
YES NO Daily medication

Please expand on all circled items: _____

_____

_____

_____

ADDITIONAL CONSENTS

I give my consent to allow the adults listed below to bring my child to Harrisonburg Pediatric Dentistry for care and to discuss protected health information at the time of the visit as needed to facilitate the medical care of my child:

Name	Relationship to Child	Phone Number

YES NO If your child qualifies for our "No Cavity Club" or other contests, may we have permission to place their first name and picture on our social media sites?

YES NO Please send me your newsletter email _____