8303 Arlington Blvd, Suite: 104
Fairfax, VA 22031
t. 703 207 0700 | w. www.mosaicsmiles.com

Patient Information

Name:______________________________________ Birth Date:_______________ Age:________ Sex ❑ M ❑ F

Street address:____ City:______________ State:_____ Zip:_____

Parent Home Phone:______________ Cell Phone: ______________________ Work Phone:_______

Email:____

How did you hear about our practice? ____

Emergency Contact______________ Relation to Patient________________ Phone ______________________

Responsible Party Information

❑ **Mother** ❑ **Father**

Name____ Birth Date ______________________

Relation to Patient________________ Phone_________________________ Soc. Sec. # ____________________

Address (if different from patient's) ____

Employer_______________________ Occupation______________________

Insurance Information

Policy Holder's Name________________________ Relation to Patient________________ Birth Date _________________

Insurance Company Name_______________________ Insurance Company Phone #:______________________

Policy Holder's Employer's Name: _________________ Subscriber ID #:_____________

Policy Holder's Address (if different from patient)_______________________ Policy Holder Phone #:________

Secondary Insurance? ❑ Yes ❑ No If Yes Specify Same Information as above:________________________

____

Medical History

Do you have any general health problems? ❑ Yes ❑ No Please specify ____

Is your child currently under physician's care? ❑ Yes ❑ No Reason ____

Name and phone of physician ____

Is your child taking any drugs or medications? ❑ Yes ❑ No Please list ____

____

Is your child you allergic to: ❑ Penicillin ❑ Codeine ❑ Latex

❑ Plastic ❑ Dyes ❑ Metals

Check X if your child has or have had any of the following:

- ❑ Anemia
- ❑ Abnormal Bleeding
- ❑ ADD/ADHD
- ❑ Arthritis
- ❑ Artificial Heart Valves
- ❑ AIDS/HIV
- ❑ Asthma
- ❑ Autism Spectrum
- ❑ Chicken Pox
- ❑ Cancer
- ❑ Congenital Heart Defect
- ❑ Convulsions
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Handicaps/Disabilities
- ❑ Hearing Impairment
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Hives
- ❑ Immune Suppressive Therapy
- ❑ Kawaski Disease
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Low Blood Pressure
- ❑ Lupus
- ❑ Measles
- ❑ Mitral Valve Prolapse
- ❑ Mononucleosis
- ❑ Scarlet Fever
- ❑ Tuberculosis

Signature Of Patient/Legal Guardian____ **Date** _____________

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Dental History

- **Previous Dentist Name:___________Last visit date: _________**
- Why did you bring the child to see the dentist today?____________________________________
- Has the child ever taken any diet pills such as Phen-Fen? ❑ Yes ❑ No
  (Also known as Redux or Pondimin) If so, when?________________
- Is the child currently in pain? ☐ **Yes ❑ No**
- Does the child require antibiotics before dental treatment? ❑ **Yes ❑ No**
- Has the child ever had a serious/difficult problem associated with previous dental work? ❑ **Yes ❑ No**
- Is the child's water fluoridated? ❑ **Yes** ❑ **No**
- Is the child taking fluoridated supplements?... ❑ **Yes** ❑ **No**
- Has the child ever had any pain/tenderness in his/her jaw joint?................................. ❑ Yes ❑ No
- Do you ever avoid any part of the mouth while brushing?.. ❑ Yes ❑ No
- Does the child brush his/her teeth daily?... ❑ Yes ❑ No
- Does the child floss his/her teeth daily?... ❑ Yes ❑ No

Please circle the following: Does/did the child experience any of the following?

Y	N	Bottle for Feedings	Y	N	Mouth Breather
Y	N	Breast Fed	Y	N	Nail Biting
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/finger Sucking
Y	N	Tongue/Cheek Sucking	Y	N	Lip Sucking/Biting
Y	N	Tongue Thrust	Y	N	Dental Phobia
Y	N	Pacifier			

Why did your child leave his/her last dentist or this his/her last time? _______________________

Remarks (For Doctor & Hygienist Only)

____
____
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