MONTGOMERY HEALTH CENTER - CHILD

To speed up the check in process, please fill in ALL information

Do you receive services at any of our other sites? Please check all that apply:

☐***Sterling Healthcare*** ☐***Sterling Women's Health*** ☐***Bath Family Health Services*** ☐***Nicholas Family Health Services***

How were you referred to Montgomery Dental Care? _____

GUARDIANSHIP INFORMATION

Are you the child's legal guardian? ☐Yes ☐No

If you marked no, who has legal guardianship? _____

****If you are not the biological or adoptive parent, you must provide legal documentation of guardianship****

For Office Use Only:

Guardianship verification received: Date _____ Employee Initials_____

DEMOGRAPHIC INFORMATION

Last Name: _____ **First Name**:_____ **Middle Name:** _____

Nickname:_____ **SSN:**_____ **Birth Date:**_____

Gender Identity:

□Male □Female □Transgender Male/Female to Male □Transgender Female/Male to Female □Other □Choose not to disclose

Sexual Orientation: □Lesbian or Gay □Bisexual □Straight □Don't Know □Choose not to disclose

Race: □American Indian/Alaskan Native □Asian □Black/African American □Native Hawaiian □White □ Other

Ethnicity: □Hispanic/Latino □Non Hispanic/Non Latino

Preferred Language: □English □Spanish □Interpreter Needed

Pharmacy: _____

Address:_____ **Zip Code**:_____

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Email Address: _____ **Preferred Communication**: Phone/Email

Preferred Phone Contact: □Home □Cell □Work

Living Situation □ Homeless □Transitional □Doubling Up □Street □Other □Unknown □Not Homeless

Agricultural Worker □ Migrant □Seasonal **Are you a Veteran** □Yes □No

Who is your Primary Care Provider? _____

Pharmacy: _____

In case of Emergency, please contact:

Name_____ **Phone:** _____ **Relation:**_____

Address_____

INSURANCE INFORMATION:

Primary Insurance: _____ **ID#**_____ **GROUP#**_____
Secondary Insurance: _____**ID#**_____ **GROUP#**_____
Subscriber Name:_____**Subscriber Date of Birth**_____
Subscriber Gender: □Female □Male **Subscriber Phone**_____
Subscriber Address if different from Patient:_____
Subscriber Employer:_____

GUARANTOR INFORMATION

Guarantor Name:_____ **Guarantor Date of Birth:**_____
Employment Information:
□Full-time □Part-time □Unemployed □Full-time Student □Part-time Student
□Retired □Unknown □Active Military Duty
Employer Name: _____ **Employer Phone**:_____
Employer Address: _____

CHILD NEW PATIENT MEDICAL HISTORY

How were you referred to our practice? _____
Please list your primary care doctor/provider and contact number:
Provider Name: _____ Phone Number: _____

ALLERGIES

Medications	
Vaccines	
Food	
Latex	
Other	

CURRENT MEDICATION(S)

Medication Name	Dosage	Directions

CHILD'S PAST MEDICAL HISTORY

Any recent Emergency room or urgent care visits? □Yes □No
If yes, please explain _____

HAS YOUR CHILD EVER BEEN TREATED FOR ANY OF THE FOLLOWING:

Condition	Y	N	Condition	Y	N
Allergies			Ear Infections		
Asthma			Chicken Pox		
Eczema			Urinary Tract Infection		

Seizures			Acne		
Heart Murmur			Serious Injury or Concussion		
Wheezing			Developmental and/or Speech Problems		
Pneumonia			ADHD/ADD		

(For girls only): Has she started her menstrual cycle? ☐Yes ☐No If so, at what age _____

Other history of chronic problem? _____

SOCIAL HISTORY

Does anyone in the house smoke? ☐Yes ☐No

Is there anything more you would like us to know about your child? ☐Yes ☐No

If yes, please explain

_____

_____

DENTAL HISTORY

What is the reason for your dental visit today? Exam Pain/swelling Broken tooth/filling

How long has this been a problem or concern? _____

When was your last dental visit? _____

Reason for that visit: _____

Have you ever been shown how to brush and/or floss? ☐Yes ☐No

How many snacks do you eat per day (candy, pop, etc.)? None 1-2 Per Day 3-4 Per Day 5-6 Per Day More than 4 per day

The above information is accurate and complete, to the best of my knowledge, and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Form completed by: _____ Relationship to child: _____

Patient/Guardian Signature _____ Date _____

Dentist's Signature _____ Date _____

Dental Caries Risk Assessment

Patient Name: _____ **Date of Birth:** _____

Address: _____

Phone Number: _____ **Social Security Number:** _____

Please circle the appropriate response for each question in the section below:			
Is your child exposed to fluoride (through tap water, supplements, professional applications, or toothpaste)?	Yes	No	
Does your child have a dentist they see regularly?	Yes	No	
Does your child have an eating disorder?	No	Yes	
Does your child abuse drugs or alcohol?	No	Yes	
How often is your child eating and/or drinking sugary foods or drinks (including candy, juice, soft drinks, energy drinks)?	Primarily at mealtimes		Frequently during the day
Has your child ever had chemo/radiation therapy?	No		Yes
Does your child have any special healthcare needs? (developmental, physical, medical or mental disabilities that prevent regular oral health care?)	No	Yes (child over age 14)	Yes (child age 6-14)
When was the last time the child's parent/guardian had a cavity?	No cavities in the past 24 months	1 or more cavities in the last 7-23 months	1 or more cavity in the last 6 months

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Cavitated or non-cavitated (incipient) carious lesions or restorations (visually or radiographically evident).	No new carious lesions or restorations in last 36 months	1 or 2 new carious lesions or restorations in last 36 months	3 or more carious lesions or restorations in last 36 months
Teeth missing due to caries in past 36 months	No		Yes
Visible plaque	No	Yes	
Unusual tooth morphology (that compromises oral hygiene)	No	Yes	
Interproximal restorations – 1 or more	No	Yes	
Exposed root surfaces (present)	No	Yes	
Restorations with overhangs and/or open margins; open contacts with food impactions	No	Yes	
Dental/Orthodontic appliances (fixed or removable)	No	Yes	
Severe xerostomia	No		Yes

For Office Use Only	Provider:	(a)	(b)	(c)
	Date:			