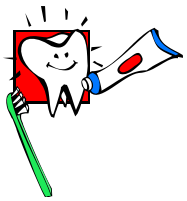

TRUNG Q. LAM, D.D.S., P.C.

14333 Laurel Bowie Road, Ste. 200, Laurel MD 20708 (301) 498-7733

Child's Information

Date _____/_____/_____

Child's Name _____ Preferred Name_____
(Last) (First) (Middle)

Date of Birth_____/_____/_____ ☐ Male ☐ Female Social Security #_____

Child's Address_____ Child's Home #_____

City_____ State_____ Zip_____

Who is Accompanying your child today?_____ Relation:_____

Parent's Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

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Mother's Information ☐ Parent/Guardian ☐ Step-Mother

Name_____ Address same as child's ☐ Yes ☐ No
(Last) (First) (Middle Initial)

Address_____ Email_____

City_____ State_____ Zip_____ Date of Birth_____/_____/_____

Home #_____ Cell #_____ Social Security #_____

Employer_____ Work #_____

Father's Information ☐ Parent/Guardian ☐ Step-Father

Name_____ Address same as child's ☐ Yes ☐ No
(Last) (First) (Middle Initial)

Address_____ Email_____

City_____ State_____ Zip_____ Date of Birth_____/_____/_____

Home #_____ Cell #_____ Social Security #_____

Employer_____ Work #_____

Dental Insurance Information

Primary_____ Secondary_____

Insured's Name_____ Insured's Name_____

Date of Birth_____ Social Security #_____ Date of Birth_____ SS #_____

Contract/ID #_____ Contract/ID #_____

Group #_____ Policy #_____ Group #_____ Policy #_____

Who is financially responsible for account?_____

Patient's Name_____ **Date of Birth**_____

Medical History

Patient's Physician_____ Date last seen_____/_____/_____

Is your child under medical care at present? □ Yes □ No If yes, specify _____

Is your child taking any medication? □ Yes □ No If yes, list medication _____

Has your child ever been hospitalized or had surgery? □ Yes □ No If yes, specify _____

Does your child have any allergies or reactions to any medications? □ Yes □ No
If yes, specify _____

Does your child have any condition requiring pre-medication before dental treatment? □ Yes _____ □ No

Please check any medical condition that the child has or has had:

□ Acid Reflux
□ ADHD
□ Anemia
□ Asperger Syndrome
□ Asthma
□ Bone or Joint Problems
□ Bruising Easily
□ Cancer or Malignancies
□ Chronic Adenoid/ Tonsil Infections
□ Cleft Lip/Palate
□ Diabetes
□ Excessive Bleeding Problem
□ Excessive Gagging
□ Generalized Anxiety
□ Hemophilia
□ Hepatitis or Liver Disease
□ Heart Disease
□ Heart Murmur
□ HIV
□ Kidney Disease
□ Leukemia
□ Oral Ulcers
□ Rheumatic Fever
□ Seizure Disorder
□ Tuberculosis
□ Other_____

Dental History

Is this your child's first visit to the dentist? □ Yes □ No If no, date of last visit_____

What is the purpose of your child's dental visit with us today? _____

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

Is your drinking water fluoridated? □ Yes □ No If not, does your child receive fluoride supplements?_____

Did your child ever take a bottle or sippy cup to bed? □ Yes □ No

Has your child had any history of:

□ Toothaches
□ TMJ (Jaw pain)
□ Sensitivity to Cold/Hot
□ Tongue Thrusts
□ Bleeding Gums
□ Thumb/Finger Sucking
□ Pacifier Use
□ Nail Biting
□ Trauma to Tooth/Face/Chin
□ Lip Sucking/Biting
□ Clenching/Grinding

I understand that the information that I have given above is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is also my responsibility as the parent/guardian to inform the office of any changes in my child's health or change in medication.

Authorization and Release

I authorize Dr. Lam to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to Dr. Lam otherwise payable to me for services rendered. I authorize the use of my signatures on all insurance submissions. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

Signature of Parent/Guardian _____ Date_____