Children's Dentistry
of Charlottesville

Pantops Orthodontics

"Braces for All Ages"

G. "Joe" Rebellato, DDS, PC

PATIENT INFORMATION FORM

Today's Date
___/___/___

Patient's Name:

_____
(Last) (First) (MI)

Address:_____
(Street) (City) (State) (Zip)

Home Phone:_____ Patient's Date of Birth: _____

Patient's Social Security Number:_____ Race:_____ Sex: Male Female

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Name of Person Bringing Patient to Appointment: _____

How are you related to this patient? (i.e., natural mother, foster father, stepmother, grandparent, etc.) _____

Do you have legal custody of this patient? YES or NO

Address:_____
(Street) (City) (State) (Zip)

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

Email Address: _____

Preferred Contact Method for confirmation: Phone Call Text to Cell Phone E-mail

Is responsible party a member of the Armed Forces? Yes No

Parent/Guardian Social Security Number: _____

In Case of Emergency Contact: _____

Relationship to Patient:_____ Emergency Contact Phone:_____

Parent/Guardian
Signature:_____

Name of Insurance Company: _____

Full Name of Policy Holder: _____ Date of Birth: _____

Policy Holder's Social Security #: _____Relationship to Patient: _____

Employer: _____

Policy Holder's Home Phone: _____ Work Phone: _____

Policy Holder Address (if different from address above): _____

_____

Patient's name:_____ Date:_____

Patient's Phone #: _____ Patient's Address:_____
Alternate Phone # _____ _____
Email Address:_____

Who else provides healthcare services to your child?
Pediatrician: _____ Phone#_____
Primary Care: _____ Phone#_____
Other:_____ Phone#_____

Does your child have any prescribed medications? YES NO If yes, please list the medication(s) and what they are used to treat:_____

_____

Has your child ever been hospitalized, had general anesthesia or emergency room visits? YES NO
If yes, please explain: _____

_____

Does your child have any allergies? (food, medication, dye, latex, etc.) YES NO If yes, please explain:
_____

_____

Have you ever been told that your child needs to take medication before dental appointments? YES NO

If Yes, please explain:_____

Please circle any of the following conditions for which your child has been diagnosed or treated:

ADD and/or ADHD	Cerebral Palsy	Heart Conditions/Murmur	Sickle Cell Trait/ Disease
AIDS/HIV	Cleft lip/ Palate	Hepatitis	Sleep Apnea
Anemia	Congenital Birth Defects	Kidney Disease	Speech/Hearing Problems
Asthma	Diabetes	Liver Disease	Stomach/ GI Disease
Autism	Down Syndrome	Mental Delay	Tonsil/Adenoid Issues
Blood/Bleeding Disorders	Epilepsy/Seizures	Premature Birth	Tuberculosis
Cancer/Tumors	Headaches	Rheumatic Fever	Other

Please elaborate on all circled items above:_____

_____

As required by Virginia law, this notice is being provided that this practice may use this information and other sources of information to request reports from the Virginia Prescription Monitoring Program for prescriptions dispensed to a patient or prospective patient.

My signature below attests that this information is correct to the best of my knowledge.

_____ _____
(Signature and relationship to patient) (Date of Visit)

TO BE COMPLETED AT NEXT VISIT: I certify the information above is still correct as of date listed below:

Please confirm current address: _____ Home #_____ Cell # _____

Date:_____ Signature/Relationship to Patient _____