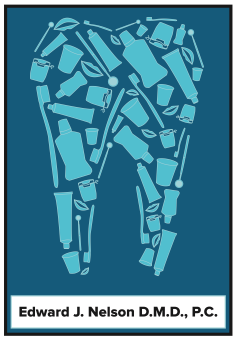


LC#_____
FM#_____
DATE_____

Edward J. Nelson, DMD PC
2501 N. Glebe Rd.
Suite # 100
Arlington, VA 22207

CHILD'S REGISTRATION AND HISTORY

Child's Name Nickname Sex Age Birthdate

Home Address City State Zip

School Address Grade

Father's Name Mother's Name

Father employed by How long Home Phone Bus. Phone

Mother employed by How long Home Phone Bus. Phone

Person financially responsible Address Relationship to child

Father's Social Security number Driver License no. State

Mother's Social Security number Driver License no. State

Father's Birthdate Mother's Birthdate

Whom may we thank for referring you? Address

Child's favorite: sport, toy, hobby, person, fictional character

Other family members in our practice?

DENTAL HISTORY

Date of last visit to dentist_____ For what service_____
Has child complained of dental problems_____
Any unhappy dental experiences_____
Any injuries to mouth-teeth-head_____
Any mouth habits-thumbsucking, nail biting, mouth breathing, nursing bottle habits, pacifier, etc._____
Any unusual speech habits_____
Any lost teeth_____
Have missing teeth been replaced_____
Orthodontic appliances worn now or ever been_____
Does your child brush teeth daily_____How often_____
Do you assist your child with tooth brushing_____
Is dental floss used_____How often_____
Is fluoride taken in any form_____
Child's attitude to dentistry_____
Do you desire complete dental service for the child_____

OVER

HEALTH HISTORY

Child's Physician Address Phone

Date of last physical exam_____Results_____

Is child under the care of a physician now_____
Is child receiving any medication or drugs_____
Is there any excessive bleeding when cut_____
Has child ever been hospitalized_____
Has child ever had surgery_____
Is there any allergy to penicillin or other drugs_____
Are there any other allergies: food-pollen-animals-etc._____
Does child have good physical coordination_____
Are there any emotional problems_____
Has child had any history or difficulty with any of the following

___Anemia	___Chronic sinus	___Hearing	___Malignancies
☐ Asthma	☐ Convulsions	___Heart	___Rheumatic fever
☐ Bladder	☐ Diabetes	___Kidney	___Mononucleosis
___Epilepsy	___Liver	___Mumps	☐ Cerebral Palsy
___Thyroid	☐ Tuberculosis	___Fainting	☐ Chicken Pox
☐ Measles	___Venereal disease	___Mastoid	___HIV (AIDS)

SUMMARY: (for doctor's use)

_____
_____
_____

Please describe any current medical treatment including drugs, pending surgery, recent injuries, or any other information I should be aware of that we have not discussed.

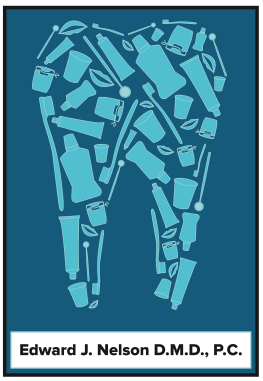
_____
_____
_____

May we request release of your child's medical records for our reference_____
This information was given by_____
Relation to child_____

POLICY CONCERNING PAYMENT OF DENTAL BILLS

Payment is expected when services are rendered. You may pay in the form of cash, check, money order, or credit card. We will provide a computer printout detailing services rendered. You may then submit this form to your insurance carrier for reimbursement. Unusual situations will be handled on an individual basis. Orthodontic treatment may be paid on a monthly schedule. These payment plans are determined and discussed by the doctors and parents/patients on a case by case basis.

Preferred Method of Payment: ☐ Cash ☐ Check ☐ Credit Card
The undersigned agrees to promptly pay all charges when billed for dental services rendered and the persons listed below agree and do hereby become legally responsible for any and all charges incurred for the patient named above. _____
Signature



EDWARD J. NELSON, D.M.D., P.C.

DIPLOMATE OF THE AMERICAN BOARD
OF PEDIATRIC DENTISTRY

2501 NORTH GLEBE ROAD
SUITE 100
ARLINGTON, VIRGINIA 22207

TELEPHONE (703) 525-8200

Dear Parents,

Welcome to the office of Dr. Edward J. Nelson, DMD, and Dr. Rose Marie Gonzales DDS. Our Office is here to serve you and your dental needs.

There are several things that will make your first visit with us go smoothly. Plan to be with us at least 45 minutes to an hour. We will do our best to see you at your appointed time, however please keep in mind that we are a pediatric dental/orthodontic practice and emergencies do arise.

Please bring the following with you at the first appointment:

- A list of any medications that the child is taking or needs to take before a dental appointment.
- Insurance card.
- Any x-rays or reports from previous dentists.

The two insurance companies that we are in network with are Delta Dental, and United Concordia. As a provider we have NO information about your insurance policy, and what they will or will not cover. As a subscriber it is your responsibility to ask questions and to check with your insurance company concerning coverage. If you are with another insurance company besides the fore mentioned, payment is required at time of service and we will supply paperwork for you to submit.

If we can answer any questions, please don't hesitate to ask. We will assist you in any way that we can.