



Jenny Jackson, DMD, MPH Phone: 828-277-6788 Email: drjackson@ashevillededo.com

PATIENT INFORMATION AND HEALTH HISTORY FORM

Child's Name: _____ Nickname: _____ Date of Birth ___/___/___
Street Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____ SSN: _____ - _____ - _____ Age: _____ Sex: Male Female

PARENT INFORMATION

Parent/Legal Guardian: _____ Relation to patient: _____
Employer: _____ Work #: _____ Mobile #: _____ Date of Birth ___/___/___
Parent/Legal Guardian: _____ Relation to patient: _____
Employer: _____ Work #: _____ Mobile #: _____ Date of Birth ___/___/___
Guardian's Email: _____
Who has legal custody? _____ Dental Insurance Yes No
Person responsible for payment of account _____ SSN#/Member ID#: _____
Driver's License # _____

WHOM MAY WE THANK FOR REFERRING YOU?

Name: _____
 www.ashevillededo.com Phone Book Dental Office Pediatrician Other

EMERGENCY CONTACT (other than parents)

Name: _____ Relationship: _____
Home Phone: _____ Work Phone: _____ Mobile: _____

HEALTH PROVIDER

Child's Physician/Pediatrician: _____ Phone#: _____
Mailing Address: _____ City: _____ State: ___ Zip: _____

DENTAL HISTORY

What is the reason for your child's dental visit? _____
 Yes No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____
Name of previous dentist: _____ Phone: _____
 Yes No Has your child experienced any unfavorable reaction from previous dental care?
Explain _____
 Yes No Does your child suck a finger, thumb, or pacifier?
 Yes No Does your child go to bed with a bottle or sippy cup? If so, what is in it? _____
 Yes No Does your child snack frequently? What are their favorite snack foods? _____
 Yes No Has your child had local anesthetic? Were there any problems? _____
 Yes No Has your child been sedated for dental treatment? Were there any problems? _____
 Yes No Have your child's teeth ever been injured? Which teeth: _____
Dental treatment for trauma: _____
 Yes No Has your child or anyone in your immediate family ever had a cavity? If so, who and when? _____

Please check if your child is having problems with any of the following:

- | | | | |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Cavities | <input type="checkbox"/> Toothache | <input type="checkbox"/> Sensitive Teeth | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> Trauma | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Color of Teeth | <input type="checkbox"/> Other |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw Sounds | <input type="checkbox"/> Grinding of Teeth | |

Comments: _____



FLUORIDE HISTORY

- Yes No Is your home water supply fluoridated?
 Yes No Does your child use a fluoride toothpaste?
 Yes No Do you give your child any other forms of fluoride? What? _____

MEDICAL HISTORY

- Yes No Is your child in good health? Date of last physical exam _____
 Yes No Has your child ever had a health problem? _____
 Yes No Is your child allergic to anything? _____
 Yes No Is your child currently taking any medications? Please give medication, dose, and reason: _____
 Yes No Are your child's immunizations current?
 Yes No Have you ever been told that your child needs to take *antibiotics before dental treatment*?
 Yes No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: _____
 Yes No Were there any difficulties at birth? _____

Do you consider your child to be: advanced progressing normally or slow in the learning process

Please check if you child has been treated for any of the following:

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Bleeding/transfusions | <input type="checkbox"/> Asthma/breathing |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Blood dyscrasias | <input type="checkbox"/> Tonsil/adenoid problems | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Liver/GI disease | <input type="checkbox"/> Sickle cell disease/trait | <input type="checkbox"/> Diabetes | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mental delays |
| <input type="checkbox"/> Speech/hearing | <input type="checkbox"/> Seizures | <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Physical delays |
| <input type="checkbox"/> Eyesight | <input type="checkbox"/> Congenital birth defects | <input type="checkbox"/> Personality/social | <input type="checkbox"/> Cancer/tumors |
| <input type="checkbox"/> Recurrent headaches | <input type="checkbox"/> Frequent Infections | <input type="checkbox"/> Adverse drug reactions | <input type="checkbox"/> Cerebral palsy |
| <input type="checkbox"/> Significant injuries | <input type="checkbox"/> Endocrine/growth | <input type="checkbox"/> Autism | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Spina bifida | <input type="checkbox"/> Snoring | <input type="checkbox"/> Abuse |

Other: _____

If any boxes checked, please describe further: _____

CONSENT FOR DENTAL TREATMENT

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Jenny Jackson and her staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, fluoride treatment, any necessary dental treatment for my child's teeth, X-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Dr. Jackson, whether or not I am present when the treatment is rendered. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Jackson will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. I will be responsible for any charges incurred for my child for dental treatment.

For the purposes of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Asheville Pediatric Dentistry of any changes in my child's medical status.

Legal Guardian's Signature: _____ **Date:** _____

Doctor Signature: _____ **Date:** _____

