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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.ashevillepedo.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 (Please circle)? If so, when? _____________________
□ 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?__________
____
□ Yes □ No Has your child or anyone in your immediate family ever had a cold sore or other mouth ulcer? Please describe: ____

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

□ Cavities	□ Toothache	□ Sensitive Teeth	□ Mouth Breathing
□ Trauma	□ Gum Infections	□ Color of Teeth	□ Other
□ Orthodontics	□ Jaw Sounds	□ Grinding of Teeth	

Comments: ____

For office use only
CRA: L M H _____________

FLUORIDE HISTORY

□ Yes □ No Is your home water supply fluoridated or does your child have other access to fluoridated water?
□ 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:

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