Holly Springs Family Dentistry   Meredith D. Taylor, DDS

Demographic Information

Patient________________________ Today's Date__________
Name child would like to be called________________ Home Phone__________
Birthday____________ Age______ Sex______ Cell Phone__________
Guardian's Email
Home Address______________________________
street *town* *state* *zip code*
Names *and ages* of other children in family________________
School________________________ Grade__________
Guardian 1: ____________________ Relation to patient__________
Employer________________________ Phone__________
Guardian 2: ____________________ Relation to patient__________
Employer________________________ Phone__________
Who has legal custody of patient?________________ Dental Insurance: ☐ Yes ☐ No
Person responsible for payment of account__________ SS#__________ DOB__________
Name of child's physician/group________________ City/St__________ Ph #__________
Whom may we thank for referring you to us?________________
What is the reason for your child's dental visit?________________

Health 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 Has your child ever been hospitalized? Please give reason and dates__________
☐ 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 Were there any problems at birth?__________

Please circle if your child has been treated for any of the following:

☐ Heart disease	☐ Bleeding/transfusions	☐ Asthma/breathing	☐ Blood dyscrasias
☐ Liver/GI disease	☐ Anemia	☐ Diabetes	☐ AIDS
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis	☐ Mental delays
☐ Speech/hearing	☐ Seizures	☐ Cleft lip/palate	☐ Physical delays
☐ Eyesight	☐ Congenital birth defects	☐ Personality/social	☐ Other problems
☐ Cancer/tumors	☐ Recurrent headaches	☐ Frequent infections	☐ Adverse Drug reations
☐ Cerebral palsy	☐ Significant injuries	☐ Endocrine/growth	☐ Autism

Please elaborate on any items circled:____________________
____
____
____

Office use only

-over-

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

Was your child ☐ breast fed ☐ bottle fed at what age was it stopped?________

Dental History

☐ Yes ☐ No Has your child ever been to the dentist? Date of last xrays (if taken)________
Name of dentist and date________________________________

☐ 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 have pain with chewing, yawning, or wide opening?

☐ Yes ☐ No Does your child's jaw make noise and is pain associated with the sounds?

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

☐ Cavities ☐ Toothache ☐ Teeth Sensitive
☐ Trauma ☐ Gum Infections ☐ Color of teeth
☐ Orthodontics ☐ Jaw Sounds ☐ Other

Comments: ________________________________
____

Fluoride History

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☐ Fl- City Water
☐ Pvt. Well
☐ Public Well ______ppm
☐ H_2O test kit given

☐ 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 form of fluoride? What?________

☐ Yes ☐ No Does your child participate in a school fluoride rinse program?

Consent for Dental Treatment

I request and authorize Dr. Taylor to examine, clean, and provide dental treatment on my child's teeth. This treatment may include sealants, restorations(fillings) or crowns if necessary. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Taylor to diagnose and/or treat my child's dental problem(s). I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Taylor will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature ________________________________ Date ____________