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Judy S. Laxer DDS, Cert. Pedo **Sonny Long DDS, MS** **Matthew F. Savage DDS, MS**

C. Marshall Long DDS, MS **Laurie Campbell DMD, MS**

Your kindness in furnishing the following information will be appreciated and will be used in strict confidence to prepare your child's clinical chart.

Patient Information

Date: _____
Child's legal name: _____ Name Child goes by: _____
Date of Birth: _____ Sex: _____ School: _____ Grade: _____
Address: _____ City: _____ Zip: _____
What are the child's interests? _____
Brothers: Names, Ages: _____
Sisters: Names, Ages: _____
Who may we thank for referring you to us? _____

Responsible Party Information

Please have insurance information and driver's license available at appointment.

Mother's Information

Name: _____ SS#: _____ D.O.B. _____
Drivers License #: _____ Marital Status: _____
Billing Address (if different): _____ City: _____ Zip: _____
Home Phone: _____ Work: _____ Mobile: _____
Email: _____ Employed by: _____
Name of Mother's Dentist: _____

Father's Information

Name: _____ SS#: _____ D.O.B _____
Drivers License #: _____ Marital Status: _____
Billing Address (if different): _____ City: _____ Zip: _____
Home Phone: _____ Work: _____ Mobile: _____
Email: _____ Employed by: _____
Name of Father's Dentist: _____

Emergency Information

Name of emergency contact not living with you: _____
Home #: _____ Mobile # _____
Relationship to patient: _____

May we request release of your child's medical records for our reference? Yes / No _____

Dental History

Child's Legal Name: _____ Date: _____
Date of last Dental Visit: _____ For what service: _____
Has child complained about dental problems? Yes / No If so, what?_____
Any unhappy dental experiences? Yes / No If so, what? _____
Any injuries to mouth-teeth-head? _____
Any mouth habits- thumb sucking, nail biting, mouth breathing, nursing, bottle habits, pacifier, etc?

_____
Any orthodontic appliance worn? _____
Does your child brush daily? Yes / No
Do you assist your child with brushing? How often? _____
Is dental floss used? How often? _____
Does your child snore at night? Yes / No
Water Source? Bottled _____ City _____ Well _____
Is fluoride taken in any form? _____
Child's attitude toward dentistry? _____

Medical History

Child's Physician: _____Address:_____
Phone #: _____ Date of last exam: _____
Does child need antibiotic pre-medication before dental care? _____
Is child under care of physician now? _____
Any Medications? For what? _____
Any excess bleeding when cut? _____
Has child ever been hospitalized? When? Why? _____
Has child ever had surgery? When? For What Reason?_____
Allergies to penicillin or other drugs? _____
Other allergies: Food- pollen-animals-etc? _____
Is child receiving any type of therapy? Occupational, physical, etc._____
Any developmental delays? _____

Does Child Have Any History of or Difficulty with any of the Following?

☐ ADD	☐ Chronic Sinus	☐ Heart	☐ Mononucleosis
☐ Anemia	☐ Convulsions	☐ Kidney	☐ Mump
☐ Asthma	☐ Diabetes	☐ Liver	☐ Rheumatic Fever
☐ Bladder	☐ Epilepsy	☐ Malignancies	☐ Thyroid
☐ Cerebral Palsy	☐ Fainting	☐ Mastoid	☐ Tuberculosis
☐ Chicken Pox	☐ Hearing	☐ Measles	Other: _____

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

_____
_____
_____

I understand by signing below that I am legally responsible for all fees incurred and that all above information is correct to the best of your knowledge. Thank you.

Signature of Responsible Party: _____ **Date:** _____