CHILDREN'S DENTISTRY OF LITHONIA

Thank you for allowing us to care for your child's dental health. Our goal is to have every child and parent that visits our practice leave with a better understanding of their dental health. We promise to do our best to provide your child with the finest care available for both the treatment and prevention of dental disease.

YOUR CHILD'S INFORMATION __ Male __ Female

Name: ____ Nickname :_____________________ Date of Birth: ___________
Address: _______________________________________ City: ___________ _______________State:____ ZIP: _____________
School Name: _________________________ Age: ____ Grade: ____ Interests: ___________________________________
Pediatrician Name: ____ Pediatrician Phone # ___________________________
Pediatrician Address: ____ City: ___________ State:____ ZIP: __________

GENERAL INFORMATION

How did you hear about our practice?____
Who is accompanying the child today? __________________________What is your relation to this child?_____________
Will you be accompanying this child to all of their visits? __yes__no Do you have legal custody of this child? __yes__no
Does this child have siblings in this practice? __yes__no
Name of person responsible for this child's account: ____

PARENT'S INFORMATION

1) Name: ____ SSN :________________________ Date of Birth: ___________
Address: _______________________________________ City: ___________ _______________State:____ ZIP: _____________
Driver's License # __________________ Work # _________________ Home# _________________ Cell #_________________
E-mail Address: _______________________________________Employer: ____
Maritial Status: __Single__Married__Partnered__Widowed/Widower__Divorced__Separated
Relation: __Mother__Father__Guardian_ _Step Mother__Step Father
2) Name: ____ SSN :________________________ Date of Birth: ___________
Address: _______________________________________ City: ___________ _______________State:____ ZIP: _____________
Driver's License # __________________ Work # _________________ Home# _________________ Cell #_________________
E-mail Address: _______________________________________Employer: ____
Maritial Status: __Single__Married__Partnered__Widowed/Widower__Divorced__Separated
Relation: __Mother__Father__Guardian_ _Step Mother__Step Father

INSURANCE INFORMATION

Name of Insured: ____ Insurance Company Name: ________________________
Insurance Company Address: _______________________________________ City: ___________ State:____ ZIP: __________
Group # ____________ Union/Local/Policy # _____________ Deductible: _______ Max annual benefit: _______

DENTAL HISTORY

Reason for today's visit:____Is this your child's first dental visit?__yes__no
Check (√) if you child has problems with any of the following

__ Bad breath	__ Grinding teeth	__ Poor past dental experience
__ Bleeding gums	__ Injury to mouth or teeth	__ Sensitive while biting
___ Broken fillings/Chipped teeth	__ Loose teeth	__ Sensitive to sweet /temp
__ Clicking/Popping jaw	__ Mouth breather	__ Sores/growths in mouth
__ Crowded teeth	__ Pacifier user	__ Sucks thumb/fingers
__ Food collection between teeth	__ Periodontal treatment	__ Toothache/Cavities

How many times a day are your child's teeth brushed/flossed? _________/__________
Are there any other dental concerns: ____

Please fill out and sign health history on reverse side of this document.

MEDICAL HISTORY

Check (V) if your child has ever had any of the following diseases/disorders:

y__n__ Adenoid/Eye/Tonsil/ Ear Problems - If yes, explain: ____
y__n__ ADD/ADHD – What type of therapy is effective at treating condition? ______________________________
y__n___Anemia/ Sickle Cell/ Thalassemia – Frequency of crisis: ________Date of last hosp/crisis: ________/__________
y__n__ Artificial Limbs/Joints - If yes, explain: ____
y__n___Asthma - Frequency of episodes: _______________________Date of last hosp/episode :___________/_________
y__n__ Autism – At what age does your child function?____ What oral textures does your child dislike?______________
y__n___Birth Defect - If yes, explain: ____
y__n___Bronchitis – Chronic or Acute?____________Frequency/Duration: _____/_____Triggers: ____________________
y__n__ Cancer - If yes, explain: ____
y__n___Cerebral Palsy - What type?____________Any mental disability? _______Any Physical Restrictions?___________
y__n__ Congenital Heart Disease - If yes, explain: ____
y__n__ Cystic Fibrosis - What type of therapy is being used?____
y__n__ Developmental Delay - If yes, explain: ____
y__n__ Diabetes – Type: _____________ Frequency of crisis: ________Date of last hosp/crisis: _________/__________
y__n___Down Syndrome – At what age level does your child function?____Any heart conditions?____________________
y__n___Fainting/ Head Injury/Brain Injury - If yes, explain: ____
y__n__Gastro-esophageal Reflux Disease (GERD) – Frequency:____Exacerbating Foods/Events:_____________________
y__n__Heart Murmur - If yes, explain: ____
y__n__Hemophilia/vWD - Type:____________Port?____Measures to prevent bleeding:________________________
y__n___Hepatitis – Type:______________Date of last hosp:__________Type of therapy:__________________________
y__n___HIV/AIDS – What type of ongoing care does your child receive?____________________________________
y__n__Muscular Dystrophy – What type of therapy does your child receive?_________________________________
y__n__ Seizure Disorder – Type: ______ Frequency/Duration: _____/_____Triggers: ___________
y__n__ Snoring /Obstructive Sleep Apnea - If yes, explain: ____
y__n___Spina Bifida – What type?___________ Any physical disability? __________________________Latex Allergy?____
y__n___Stomach/ Kidney /Liver Problems - If yes, explain: ____
y__n__Tuberculosis – How long has your child had the disease? ______________________Is the disease active?_______

Are your child's immunizations up to date? y__n___If no please explain:_______________________________________
Is there a chance that your child could be pregnant ?y__n___If yes please explain:__________________________________
Describe any episodes where your child required surgery: ____
Describe any episodes where your child required a sedative: ____
Describe any episodes where your child required hospitalization: ______________________________________
List any medications, materials, or foods that your child is allergic to: _____________________________________
____
List any medications that your child is currently or has formerly taken and the correlating diagnosis:________________
____
Is there anything else that you would like to tell us about your child's medical history? ___________________________
____

To the best of my knowledge the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my child ever has a change in health.

I (We) the undersigned parent, parents, or legal guardian of___________________________________
DOB ___/___/___, a minor, do hereby authorize and consent to x-rays which may be taken along with a head and neck examination, dental cleaning, dental diagnosis, and performance of all recommended treatment which is deemed advisable by and is to be rendered under the general or special supervision of any dentist at Children's Dentistry of Lithonia.

Signature of parent/guardian:____Date:_______________