Shallotte
FAMILY DENTISTRY

Patient Information

Patient's Name_____ Preferred Name_____ Sex____
(First) (Middle) (Last)

Mailing Address_____
(Street) (City) (State) (Zip)

Date of Birth: _____ Age: _____ Weight: _____ Patient's Social Security No.: _____

Home Phone_____ Work Phone _____ Cell Phone _____

Would you like to receive text messages to confirm dental appointments? ☐ Y ☐ N

Would you like to be contacted via email to confirm dental appointments? ☐ Y ☐ N

Please indicate your preferred method of contact: _____ E-mail address: _____

Emergency contact: _____
(Name) (Phone number) (Relation)

Child lives with: Both Parents _____ Mother _____ Father _____ Other _____

Names of Siblings:

Child's Name _____ DOB _____ Age _____
Child's Name _____ DOB _____ Age _____
Child's Name _____ DOB _____ Age _____

How did you hear about Shallotte Family Dentistry? _____

Parent/Guardian Information

Mother

Name _____ DOB _____ Social Security No. _____
Marital Status _____ Employer _____ Occupation _____
Address (if different from above) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Father

Name _____ DOB _____ Social Security No. _____
Marital Status _____ Employer _____ Occupation _____
Address (if different from above) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Dental Insurance Information

Primary Insured's Name _____ Insured's Soc. Sec. No. _____

Insured's DOB _____ Primary Insured's Employer _____

Insurance Co. _____ Insurance Co address _____

Subscriber No.: _____ Group No _____ Insurance Co. Phone No _____

Parent /Guardian Signature:_____ **Date**_____

CHILD'S NAME: _____ DOB: _____ WEIGHT: _____

MEDICAL HISTORY: *Does your child currently have or has ever had any of the following?*

☐ Y ☐ N Acid Reflux
☐ Y ☐ N ADD/ADHD
☐ Y ☐ N Allergies/Seasonal Allergies
☐ Y ☐ N Anemia
☐ Y ☐ N Anxiety
☐ Y ☐ N Arthritis
☐ Y ☐ N Asthma
☐ Y ☐ N Autism
☐ Y ☐ N Bleeding Disorder
☐ Y ☐ N Bronchitis
☐ Y ☐ N Cancer: Type _____
☐ Y ☐ N Cerebral Palsy
☐ Y ☐ N Chemotherapy/Radiation
☐ Y ☐ N Congenital Heart Defect
☐ Y ☐ N Convulsion/Epilepsy
☐ Y ☐ N Depression
☐ Y ☐ N Diabetes: Type_____
☐ Y ☐ N Dialysis
☐ Y ☐ N Drug/Alcohol Abuse
☐ Y ☐ N Eating Disorder
☐ Y ☐ N Fainting Spells
☐ Y ☐ N Handicap/Disabilities
☐ Y ☐ N Headaches/Migraines
☐ Y ☐ N Hearing Impairment
☐ Y ☐ N Heart Disease
☐ Y ☐ N Heart Murmur
☐ Y ☐ N Heart Surgery
☐ Y ☐ N Hepatitis: Type _____
☐ Y ☐ N HIV/AIDS
☐ Y ☐ N Immune Suppressive Disorder
☐ Y ☐ N Kidney Problems
☐ Y ☐ N Liver Disease
☐ Y ☐ N Lung Problems
☐ Y ☐ N Mental Disorder
☐ Y ☐ N Nervous System Disorder
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Seizures
☐ Y ☐ N Smoker/Tobacco Use
☐ Y ☐ N Speech Disorder
☐ Y ☐ N STD/ Venereal Disease
☐ Y ☐ N Thyroid: Type _____
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Tumors/Growths
☐ Y ☐ N ODD (Oppositional Defiant Disorder)
☐ Y ☐ N OCD (Obsessive Compulsive Disorder)

Does your child take an antibiotic prior to dental treatments? ☐ Y ☐ N

FEMALE PATIENTS:
Are you pregnant? ☐ Y ☐ N
Are you nursing? ☐ Y ☐ N

Has your child experienced any other medical conditions not listed above? ☐ Y ☐N Please list: _____

Is your child presently under the care of a physician? ☐ Y ☐ N Physicians Name: _____Reason for care _____

Has your child ever been hospitalized? ☐ Y ☐ N Please explain: _____

ALLERGIES: Is your child allergic to any of the following?

☐ Y ☐ N Amoxicillin
☐ Y ☐ N Aspirin
☐ Y ☐ N Clindamycin
☐ Y ☐ N Codeine
☐ Y ☐ N Dental Anesthetic
☐ Y ☐ N Eggs
☐ Y ☐ N Erythromycin
☐ Y ☐ N Latex
☐ Y ☐ N Penicillin
☐ Y ☐ N Red Dye
☐ Y ☐ N Sulfur
☐ Y ☐ N Tylenol/Acetaminophen

Is your child allergic to any other medications or foods that are not listed above? _____

DENTAL HISTORY:

What is the reason for your child's dental visit today? _____ Is this your child's first visit to the dentist? ☐ Y ☐ N
How do you expect your child to behave in our office?_____
Name of previous dentist: _____ Date of last dental visit: _____
Has your child ever had a problem associated with previous dental work? ☐ Y ☐ N Please explain: _____
Has your child had any injuries to their mouth, teeth, or head? Please explain: _____

☐ Y ☐ N Does your child brush their teeth daily?
☐ Y ☐ N Does your child use dental floss?
☐ Y ☐ N Do you assist your child with brushing?
☐ Y ☐ N Does your child grind or clench their teeth?
☐ Y ☐ N Does your child suck their thumb?
☐ Y ☐ N Does your child use a pacifier?
☐ Y ☐ N Does your child's gums bleed while brushing or flossing their teeth?
☐ Y ☐ N Does your child take a fluoride supplement?
☐ Y ☐ N Does your child bite their nails?
☐ Y ☐ N Has your child had facial or jaw injury?
☐ Y ☐ N Is your child currently nursing?
☐ Y ☐ N Does your child drink from a baby bottle or sippy cup?

MEDICATIONS: Please list all the medications, vitamins and supplements your child is currently taking.

Medication and Dose	*How much do you take and when?*	*What do you take it for?*	*Date started*

If there any information you feel we should know regarding your child's dental treatment, please let us know._____

_____

*** By signing below you are agreeing that the information above is accurate and complete to the best of your knowledge and you have provided Shallotte Family Dentistry with all the information needed to insure (child's name)* _____ *has the most proper and safest care possible.*

Parent/Guardian Signature:_____ **Date**_____