peachtree hills
PEDIATRIC DENTISTRY

Patient Information

Date_____

Last Name_____ First Name_____ Preferred Name_____ Sex: M__ F__

Age_____ Birth Date_____

In the event of an emergency, whom should we contact?

Name_____ Relationship_____ Phone_____

How were you referred to our office? Our Website___ Insurance Website___ Other Doctor_____

Friend/Relative_____ Sibling_____ Other_____

Parent/Guardian Information

Father___ Stepfather___ Guardian___

Name_____ DOB_____ SSN#_____ Employer_____

Home Address_____ City_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____

Mother___ Stepmother___ Guardian___

Name_____ DOB_____ SSN#_____ Employer_____

Home Address_____ City_____ Zip Code_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____

Dental History

Reason for this visit:

Checkup/cleaning___ Dental caries___ Mouth Injury____ Toothache___ Crooked Teeth____ Oral Habits___

Other_____

Last Dental Visit and Reason_____ Dentist's Name_____

Any unhappy dental experience?_____

How do you think your child will behave during this visit?_____

Medical History

Patient's Pediatrician_____ Phone_____

Is child under the care of a physician now?___ Explain_____

Taking any medications or drugs?___ Explain_____

Ever been hospitalized?___ Explain_____

History of surgery?___ Explain_____

Any Drug/Food/Metal/Latex allergies?___ Explain_____

HAS YOUR CHILD HAD ANY HISTORY OF:

Anemia___	Cerebral Palsy___	Heart disease___	Premature birth___
Asthma___	Convulsions___	Heart murmur___	Problems with anesthesia___
Astma___	Developmental delay___	Hearing problems___	Prolonged bleeding___
ADHD___	Diabetes___	Hepatitis/Liver Disease___	Rheumatic fever___
AIDS/HIV___	Down Syndrome___	High/low blood pressure___	Seasonal allergies___
Birth defect____	Epilepsy____	Kidney disease___	Tuberculosis___
Blood disorder___	Ear, eye, nose trouble___	Lung disease___	Thyroid disease___
Cancer___	Gastric reflux___	Pregnancy___	Other___

Comments:_____

_____

Acknowledgement of Patient Information/Authorization for Initial Evaluation

The information I have given is correct to the best of my knowledge. I understand that all information is confidential, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services to my child for an initial evaluation. Any other dental services required will be explained and authorized by me after the initial visit.

_____ _____

Signature of Parent/Guardian Date