BRIT E. BOWERS, DDS
LAUREL BATEMAN, DDS
Specialists in Pediatric Dentistry
801 Sunset Drive, Bldg. D, Suite 1 • Johnson City, TN 37604 • 423-610-0556

Date _____

Child's Name _____ Sex: Male____ Female____ Age _____

Your Name _____ Relationship_____

Whom may we thank for referring you to our office? _____

Are other children in your immediate family seen here? _____ Names Please _____

Please check any information that is pertinent to your child.

Reason for Today's Appointment

❒ Check up and cleaning ❒ Exam only ❒ Crowding/braces ❒ Toothache ❒ 2nd Opinion

❒ Trauma ❒ Cavities ❒ Eruption problems ❒ Confidence Visit ❒ Other _____

Medical History

	Yes	No
Child's Physician _____		
Is your child in good health?	❒	❒
Is your child up to date with immunizations?	❒	❒
Is your child taking any medications?	❒	❒
If so, please list _____		
Is your child allergic to any medicines? (such as penicillin, codeine, xylocaine)	❒	❒
If so, please list _____		
Is there anything that we need to know about your child's physical, emotional, or mental health?	❒	❒
Is there any additional information that we should know about your child's health? _____	❒	❒

Dental History

Is this your child's first dental visit?	❒	❒
If not month/year of last visit? _____		
Has your child had an unfavorable experience at another dental office?	❒	❒
Is your child presently on a fluoride supplement?	❒	❒
Is your child a thumb/finger sucker?	❒	❒
Does your child use a pacifier?	❒	❒
Age the bottle or nursing was discontinued _____		
Has your child ever experienced trauma to the face or jaws?	❒	❒
Do you have Well or City water? _____		
Do you help your child brush?		❒
Did either parent wear braces?	❒	❒

Check Condition

- ❒ heart condition
- ❒ heart murmur
- ❒ rheumatic fever
- ❒ asthma
- ❒ seasonal allergies
- ❒ latex allergy
- ❒ food allergies_____
- ❒ bleeding disorder
- ❒ sickle cell anemia
- ❒ autism
- ❒ cerebral palsy
- ❒ brain injury
- ❒ any other handicaps_____
- ❒ hearing disorder
- ❒ vision disorder
- ❒ speech disorder
- ❒ kidney disorder
- ❒ liver disorder
- ❒ diabetes
- ❒ hepatitis
- ❒ hiv+
- ❒ cancer
- ❒ leukemia
- ❒ chemotherapy
- ❒ tonsillectomy
- ❒ mouth breathes
- ❒ epilepsy
- ❒ seizures
- ❒ tubes in ears
- ❒ pregnant

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PATIENT INFORMATION

Date _____ Email _____ Cell Phone _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Social Security # _____

Mother's Full Name _____ Father's Full Name _____

Marital Status of Parents: ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Single

RESPONSIBLE PARTY INFORMATION

Name _____ Relationship to Patient _____

Mailing Address _____

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security # _____ Birthday _____ Employer _____

Name _____ Relationship to Patient _____

Mailing Address _____

Cell Phone _____ Home Phone _____ Work Phone _____

Social Security # _____ Birthday _____ Employer _____

DENTAL INSURANCE INFORMATON

Subscriber Name _____ Soc. Sec. # _____ Birthdate _____

Subscriber Address _____ Employer _____

Insurance Co. _____ Group # _____ or Employee # _____

Insurance Co. Address _____

IF YOU HAVE SECONDARY DENTAL INSURANCE,

Subscriber Name _____ Soc. Sec. # _____ Birthdate _____

Subscriber Address _____ Employer _____

Insurance Co. _____ Group # _____ or Employee # _____

Insurance Co. Address _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____
Relationship to patient

Complete Address _____

Phone _____

(OVER)