

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? Yes No

Is your child up to date with immunizations? Yes No

Is your child taking any medications? Yes No

If so, please list _____

Is your child allergic to any medicines? Yes No

(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? Yes No

Is there any additional information that we should know about your child's health? Yes No

Dental History

Is this your child's first dental visit? Yes No

If not month/year of last visit? _____

Has your child had an unfavorable experience at another dental office? Yes No

Is your child presently on a fluoride supplement? Yes No

Is your child a thumb/finger sucker? Yes No

Does your child use a pacifier? Yes No

Age the bottle or nursing was discontinued _____

Has your child ever experienced trauma to the face or jaws? Yes No

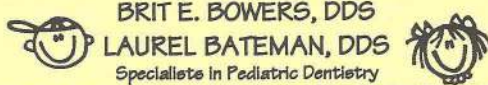
Do you have Well or City water? _____

Do you help your child brush? Yes No

Did either parent wear braces? Yes No

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



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

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 INFORMATION

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 _____