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 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)

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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