Children's and Adolescent Dentistry of Franklin
3000 Stansberry Lane #105
Franklin, TN 37069

Date_____

1. Patient Information

Child's Name _____

Goes by: _____ Male Female

Child's Birthdate ____/____/____

Child's Home Address:_____

_____

2. Who may we thank for referring you

_____

3. Mother's Information

Name_____

Birthdate ____/____/____ SS # _____

Cell Phone # (_____) _____

Work # (_____) _____ Ext. _____

Email Address:_____

4. Father's Information

Name _____

Birthdate ____/____/____ SS # _____

Cell Phone # (_____) _____

Work # (_____) _____ Ext. _____

Email Address:_____

5. Who is Accompanying the Child Today?

Name _____

Do you have legal custody of this child? Yes No

6. Primary Dental Insurance

Insurance Co. Name _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

7. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist?_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? ____

If yes, please explain _____

_____

_____

Why did you bring the child to the dentist today?

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

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8. Medical History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Allergies to Latex Product
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Autism
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver
Y N Pregnancy
Y N Rheumatic/Scarlet Fever
Y N Sensory Issues
Y N Tuberculosis

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence 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 my child may need.

_____ _____ _____

Signature of Parent or Guardian Relationship to Patient Date

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

For Office Use Only

Dr. Initials _____ Date _____