Trussville Pediatric Dentistry
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Suite 1
Trussville, AL 35173
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THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD, THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name ______________________ Preferred Name______________ Age________

Sex ______ Race ______ Date of Birth ____________ Patient's School ______________ Social Security #______________

Patient's Address____
Street City State Zip

Phone numbers for confirmation of appointment (Home) ______________ (Cell) ______________

Primary Dental Coverage______________Insured's Name______________DOB________Martial Status______

Where Employed______________Group #______________Policy #______________

Social Security #____________Relationship to Child______________

Secondary Dental Coverage______________Insured's Name______________DOB________Martial Status______

Where Employed______________Group #______________Policy #______________

Social Security #____________Relationship To Child______________

Father's Name______________________________ **Social Security #**______________
Date of Birth

His Address____ Phone______________
Street City State Zip

Where Employed____ Phone______________
Company Address

Mother's Name______________________________ **Social Security #**______________
Date of Birth

Her Address____ Phone______________
Street City State Zip

Where Employed____ Phone______________

Other children in family – names and ages ____

Account Information

Person ultimately responsible for account

Name ______________________________ Relation to child______________

Billing Address ____

City______________________ State______________ Zip______________

Social Securiy #____________ Drivers License #______________Work Phone # (____)______________

______
Initial

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.

Patient's Name: ______________________________

(Please Check)

Health History

	NO	YES
Is your child in good health?	___	___
Does your child have regular medical exams?	___	___
Are your child's immunizations up to date?	___	___
Is your child presently taking any medications? If so, what: ______________________	___	___
Has your child experienced an unfavorable reaction to any medications? If so, what: ______________________	___	___
Is your child presently undergoing medical treatment? If so, for what: ______________________	___	___
Has your child been hospitalized since birth?	___	___

Date____________ Reason________________________

Date____________ Reason________________________

Please check any of the following that may pertain to your child:

___ **Heart condition**
(Circle) *Murmur*, *Mitral Valve Prolapse*, *Artificial Heart Valves*, *Other*______________

___ Asthma

___ **Allergies**
(Circle) *Penicillin*, *Other medicines*, *Latex*, *Other*______________

___ Diabetes

___ Bleeding disorder/Blood disease

___ Sickle Cell Anemia

___ ADD/ADHD

___ Speech/Hearing/Vision disorder (circle)

___ Lung problem

___ Brain injury

___ Epilepsy/Seizures (circle)

___ Fainting spells

___ Liver problem

___ Kidney problem

___ Cerebral palsy

___ Mental retardation

___ Mental/emotional disorder

___ Autism

___ Physically challenged

___ AIDS

___ Hepatitis

___ Tuberculosis

___ Nervous disorder

It is your responsibility to keep us informed if **Health History changes.**

Habits:

	NO	YES
Is your child a finger/lip sucker?	___	___
Does your child use a pacifier?	___	___
Is your child an exclusive mouth breather or heavy snorer?	___	___
Does your child grind his/her teeth?	___	___

Feeding Habits:

	NO	YES
Was your child bottle-fed? Age discontinued? __________	___	___
Was your child breast-fed? Age discontinued? __________	___	___

What is your child's favorite fluid to drink?
(Circle) Kool-Aid, apple/orange juice, milk, formula, water, other__________

Oral Hygiene:

	NO	YES
Does your child suffer from sensitive teeth or gums?	___	___
Do you feel that your child has bad breath?	___	___

Rate your child's smile on a scale of 1-10: __________

Child's Physician__________________ Phone #______________ Family Dentist__________________ Phone #____________________

How did you hear about our office **(be specific)**?
Pediatrician _________________ Dentist _________________ Friend _________________ Ad _________________ Other _________________

Please list any pets, hobbies, favorite movies, etc. that will help us to better know your child:

If your child qualifies for our "No Cavity Club," may we have your permission to place their first name and picture on our website at www.trussvillepediatricdentistry.com
YES____ NO ____

Parent/Guardian Signature: ______________________________ **Date:** ____________________