Trussville Pediatric Dentistry
4901 Deerfoot Parkway Ste. 101
Trussville, Al. 35173
(205) 655-1000
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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 Adress_____
Street City State Zip

Phone Number/Email for confirmation of Appt._____**Email**_____

Primary Dental Coverage_____Insured'sName_____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_____DOB_____Social Security #_____

His Address_____Phone#_____
Street City State Zip

Where Employed_____Phone#_____

Mother's Name_____DOB_____Social Security#_____

Her Address_____Phone#_____
Street City State Zip

Where Employed_____Phone#_____

Other children in the family_____

Account Information: Person ultimately responsible for account:

Name_____Relationship to Child_____

Billing Address_____ _____

Social Security#_____Drivers License#_____Phone#_____

_____(Intials)

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_____

Health History	**NO**	**YES** (Please Check)
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 Treatments?	____	____
If so, 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
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 Problems
____Kidney Problem
____Cerebral Palsy
____Downs Syndrome
____Mental/Emotional Disorder
____Autism/Asperger (Circle)
____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:

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:

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:

Parent/Guardian
Signature:_____**Date:**_____