Trussville Pediatric Dentistry
4901 Deerfoot Parkway Ste. 101
Trussville, Al. 35173
(205) 655-1000
office@trussvillepediatricdentistry.com

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)

	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 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:

	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:

Parent/Guardian
Signature:________________________________**Date:**________________________________