MECKLENBURG COUNTY HEALTH DEPARTMENT

CMC-BIDDLE POINT PEDIATRIC DENTISTRY

PATIENT INFORMATION

Patient's Name _____ Preferred Name _____ Sex _____

Address _____
Street City State Zip

Date of Birth _____ Age _____ Weight _____ School _____

Social Security Number _____ Insurance/Medicaid Number _____

Names and ages of brothers and sisters _____

_____

Child's Physician _____ Date of last physical exam _____

Previous Dentist _____ Date of last dental exam _____

Whom may we thank for referring you? _____

If another dentist is referring you, what is the reason for referral? _____

_____

PATIENT/GUARDIAN INFORMATION

Your Name _____

Residence _____
Street City State Zip

Mailing Address _____

How long at this address _____ Home Phone _____ Work Phone _____

Birthdate _____ Age _____ Social Security # _____

Relationship to patient _____ Employer _____

EMERGENCY INFORMATION

Name of nearest relative or friend not living with you _____

Complete Address _____ Phone _____

FAILED DENTAL APPOINTMENTS deprive others of treatment. If you cannot keep an appointment, we ask that you notify office at least 24 hours in advance. Failure to follow this policy may result in a change of your appointment privileges.

----------**PLEASE COMPLETE OPPOSITE SIDE** ----------

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To the best of my knowledge, the medical and dental information as answered on this form is correct. I will inform this office of any changes in health status and/or use of medications.

When used for educational purposes, I consent to the use of radiographs, photographs, study models, etc.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of proper and acceptable methods to perform the same. Alternative methods of treatment, if any, have been explained to me. I am advised that, though good results are expected, the possibility and nature of complications cannot be completely anticipated. Therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the care. I further authorize the doctors to perform other dental services that, in their judgement, are advisable for my child or legal ward.

I FULLY UNDERSTAND THIS CONSENT AND HAVE NO FURTHER QUESTIONS.

Date _____ Signature of Parent or Guardian _____

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PATIENT HEALTH HISTORY

It is important to answer this information completely. Please check yes or no, circle and explain where appropriate.

Has your child had a history of or difficulty with any of the following?

(Y) (N)		(Y) (N)		(Y) (N)	
( ) ( )	AIDS or HIV infection	( ) ( )	Allergies	( ) ( )	Anemia or Bleeding Disorder
( ) ( )	Asthma or Hay Fever	( ) ( )	Arthritis or Rheumatism	( ) ( )	Brain injury
( ) ( )	Cerebral Palsy	( ) ( )	Developmental Disability	( ) ( )	Diabetes
( ) ( )	Emotional Disturbance	( ) ( )	Epilepsy	( ) ( )	Fainting or Seizures
( ) ( )	Frequent Headaches	( ) ( )	Hearing or Speech Disorder	( ) ( )	Heart Disorder or Murmur
( ) ( )	Hepatitis or Jaundice	( ) ( )	Kidney or Liver Disease	( ) ( )	Lung Problems
( ) ( )	Mental Retardation	( ) ( )	Nervous System Disorder	( ) ( )	Psychiatric Treatment
( ) ( )	Rheumatic Fever	( ) ( )	Sexually Transmitted Disease	( ) ( )	Surgery
( ) ( )	Thyroid Disorder	( ) ( )	Tuberculosis	( ) ( )	Ulcers
				( ) ( )	Latex

(Y) (N)

Has your child been diagnosed as having any disorder, disease or syndrome not listed above? ..... ( ) ( )
If yes, explain _____

Has your child had abnormal bleeding associated with previous surgery, extractions or accidents? ..... ( ) ( )

Has your child ever required a blood transfusion? ..... ( ) ( )

Does he/she bruise easily? ..... ( ) ( )

Has your child ever had surgery, x-ray or chemotherapy for a tumor, growth or other condition? ..... ( ) ( )
Explain _____

Currently pregnant or may be? ..... ( ) ( )

Currently taking birth control pills? ..... ( ) ( )

Is your child under medical care? ..... ( ) ( )

List any drugs or medications presently taking. _____

List any drug or medication allergies. _____

PATIENT DENTAL HISTORY

Is this your child's first visit to the dentist? ..... ( ) ( )

Do you/child feel nervous or concerned about dental treatment? ..... ( ) ( )
Please explain _____

Has your child had any unfavorable experiences in a dental/medical environment? ..... ( ) ( )
Explain _____

Have you been satisfied with your child's previous dental care? ..... ( ) ( )

What is your main concern about your child's dental health? _____

Has your child ever complained about pain or is there pain or discomfort presently? ..... ( ) ( )

Is your child currently taking fluoride in any form? ..... ( ) ( )
Explain _____

Is your water non-fluoridated? ..... ( ) ( )

Is there any history of nail biting, thumb or finger sucking, mouth breathing, pacifier use? (Please circle) ..... ( ) ( )

Does he/she grind or clench teeth? ..... ( ) ( )

Have orthodontic appliances been worn now or ever? ..... ( ) ( )

Is there a history of trauma or injury to the teeth, jaws or head? ..... ( ) ( )
Please explain _____

Does your child brush his/her teeth daily? ..... ( ) ( )

Does an adult assist child with brushing? ..... ( ) ( )

Is your child currently breast or bottle-feeding? ..... ( ) ( )

At what age did he/she stop? _____

Would you describe your child to be: ( ) Nervous ( ) High-strung ( ) Hyperactive ( ) Shy
( ) Frightened ( ) Uncooperative ( ) Negative ( ) Other _____

Intellectual Development: ( ) Advanced ( ) Normal Rate ( ) Delayed

If your child is in a special educational program or structure, please explain _____

Thank you for carefully answering the questions on this form. If there is any information you feel would assist us in the treatment of your child, please add it here _____