DRS ENSOR JOHNSON & LEWIS

Pediatric Dentistry

Date:_____

Personal History:

Name**:** _____Nickname:_____

Age:_____Date of Birth:_____Sex:_____School:_____Grade:_____

Number of Children in Family:_____Referred By:_____

Home Address:_____City/State/Zip:_____

Home Phone:_____Email:_____

Parent's Name:_____Parent's Occupation:_____

Cell Phone:_____Work Phone:_____

Parent's Name:_____Parent's Occupation:_____

Cell Phone:_____Work Phone:_____

Person Responsible for Account:_____

Medical History:

Patient Physician:_____

Date of Most Recent Exam:_____

Has the patient ever had any of the following conditions? (Circle if Yes)

Heart Disease, Rheumatic Fever, Brain Injury, Seizures, Skin Disorders, Asthma, Ear Infections, Tonsillitis, Bleeding Disorders, Kidney Involvement, Liver Involvement, HIV-Positive/AIDS, Other

If Other, please explain:_____

Is the patient allergic to any foods or medicine? Yes_____No_____

Has the patient ever had Penicillin? Yes____No____

Has the patient ever been hospitalized? Yes_____No_____

DRS ENSOR JOHNSON & LEWIS

Dental History:

Reason for this visit (check-up, toothache, etc.)?

_____

_____

Is this the patient's first visit to the dentist? Yes____No____

When was the patient's last dental visit? _____

Service rendered at that time?_____

Has the patient ever had any unfavorable dental experience? Yes___No___

Please explain if the answer is yes: _____

_____

Have there been any injuries to the patient's teeth? Yes____No____

Please explain if the answer is yes:_____

_____

Does/Did the patient suck his/her thumb, fingers, pacifier or lips? Yes____No___

If yes, until what age?_____

Has the patient had any previous orthodontic care? Yes___No____

If yes, when?_____

Parent or Guardian Name:_____

Parent or Guardian Signature:_____

APPOINTMENTS: Once an appointment has been made, please remember this time has been reserved especially for you. If you miss your appointment without proper notification, a $50 charge will be assessed. To avoid this charge, please call the office to reschedule your appointment at least 48 hours in advance.

I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears above, to administer any treatment agreed upon; or to administer local anesthetics, agents or drugs; to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

Signature:_____
(Parent or Guardian if Patient is Under 18)