The Greensboro Center for Pediatric Dentistry

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Patient Information

Patient Name:____
First MI Last (Preferred Name)

Birth Date:____________________ Age:____________ Sex: ☐ Male ☐ Female

Father's Name______________________________ Address____

______________________________Phone(H)__________(C)_________ DOB__/__/__ SS#__________________
City State Zip

Employed By______________________________ Position__________________Bus. Phone____________________
Name of Business

Dental Insurance____

Mother's Name______________________________ Address____

______________________________Phone(H)__________(C)_________ DOB__/__/__ SS#__________________
City State Zip

Employed By______________________________ Position__________________Bus. Phone____________________

Dental Insurance____

E-mail Address (for appointment confirmations)____

Who may we thank for referring you?____

Dental History

	YES	NO
What is your main dental concern?______ ______________________________		
Is this your child's first visit to the dentist?	☐	☐
Who was last dentist?_______________		
Last date teeth cleaned?_____________		
Has child complained about dental problems? Explain__________________________	☐	☐
Any unhappy dental experiences?________ ______________________________	☐	☐
Any injuries to mouth, teeth, or head?_____ ______________________________	☐	☐

	YES	NO
Any mouth habit: thumb, pacifier, nail biting, bottle, etc.?______________________	☐	☐
Any lost teeth?____________________	☐	☐
Does your child brush daily?___________	☐	☐
Do you help your child brush?__________	☐	☐
Is dental floss used?_______________	☐	☐
Is fluoride taken in any form?__________	☐	☐
Do you have well water?	☐	☐

Summary____
____
____

Please complete both sides

MEDICAL HISTORY

Child's Physician_____________________ Address________________________ Phone____________

Date of last physical examination _____________Results____________________________________

	YES	NO
Is child under care of physician now?____	☐	☐
Is child receiving any medications? (List Below)..	☐	☐
____		
Is there any excessive bleeding when cut?..	☐	☐
Has child ever been hospitalized?..	☐	☐
Has child ever had surgery?..	☐	☐
Are there any allergies to penicillin or other drugs? (List Below)..	☐	☐
____		
Are there any other allergies? (List Below)..	☐	☐
____		
Does child have good physical coordination?..	☐	☐
Are there any emotional issues?..	☐	☐
Any history of problems with local/general anesthesia?...	☐	☐
Are immunizations up to date?...	☐	☐

Has your child ever had any of the following? Please check those that apply:

____ADHD/ADD	____Chronic Sinusitis	____Hearing Problems	____Malignancies
____Anemia	____Developmental Delays	____Heart Problems	____Mononucleosis
____Anxiety/Depression	____Diabetes	____Heart Murmurs	____Rheumatoid Arthritis
____Asthma	____Down Syndrome	____HIV/AIDS	____Rheumatic Fever
____Autism/Asperger's	____Epilepsy/Seizures	____Kidney/Bladder Disease	____Thyroid Problems
____Cerebral Palsy	____Fainting	____Liver Disease/Hepatitis	____Tuberculosis

Are there any other conditions?____

PERMIT FOR TREATMENT UPON A MINOR

Child's Name____Age________________

I, being the parent or guardian of the above minor patient, do hereby authorize and request the performance of dental services for this patient; and further, the performance of whatever procedures the judgment of the above named doctors may deem necessary during the performance of any dental treatment.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by the doctor, with my knowledge.

Furthermore, I will be responsible for any financial obligations incurred on this child for dental treatment. I also understand that payment for treatment rendered is expected at the end of each appointment, unless other financial arrangements are made.

Parent/Guardian Signature____ Date__________________________