NC04-Taylorsville Pediatric Dentistry
167 1st Avenue SW
Taylorsville, NC 28681
Ph # : 828-635-9200

Patient Personal Information

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				Emergency Contact	Emergency Phone #
Email				Student	SSN
Health Care Guardian Name				School Name	
Health Care Guardian Phone #				Referral Type	

Person responsible/guarantor for paying bills

Title		Preferred Name		Birth Date	Age
Last, First				Marital Status	Sex
Address				Home #	Work #
				Cell #	Drive Lic
City, State, Zip				SSN	
Email					

Do you have Primary Dental Insurance? __ Yes __ No				Do you have Secondary Dental Insurance? __ Yes __ No			
Group No/Name				Group No/Name			
Insurance Name				Insurance Name			
Phone #				Phone #			
Employer Name				Employer Name			
Subscriber Last, First				Subscriber Last, First			
Subscriber Address				Subscriber Address			
City, State, Zip				City, State, Zip			
Relationship to Patient		Birth Date		Relationship to Patient		Birth Date	
Subscriber ID				Subscriber ID			

Patient Medical Information

Allergies

- ☐ Y ☐ N Any Allergies?
- ☐ Y ☐ N Aspirin
- ☐ Y ☐ N Codeine
- ☐ Y ☐ N Erythromycin
- ☐ Y ☐ N Iodine
- ☐ Y ☐ N Latex Rubber
- ☐ Y ☐ N Local Anesthetics
- ☐ Y ☐ N Epinephrine
- ☐ Y ☐ N Penicillin
- ☐ Y ☐ N Amoxicillin
- ☐ Y ☐ N Sulfa
- ☐ Y ☐ N Other Narcotics

Medical History

- ☐ Y ☐ N First Visit?
- ☐ Y ☐ N Rheumatic Fever
- ☐ Y ☐ N Rheumatic Heart Disease
- ☐ Y ☐ N If No, Any Changes?
- ☐ Y ☐ N Diabetes
- ☐ Y ☐ N Seizures or Fainting
- ☐ Y ☐ N Pre-Medication Needed
- ☐ Y ☐ N Epilepsy/Convulsions
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Asthma or Hay Fever
- ☐ Y ☐ N High Blood Pressure
- ☐ Y ☐ N Low Blood Pressure
- ☐ Y ☐ N Tuberculosis Lung Problems
- ☐ Y ☐ N Liver Problems
- ☐ Y ☐ N Hepatitis/Jaundice
- ☐ Y ☐ N Other Liver Disease
- ☐ Y ☐ N Emotional Problems
- ☐ Y ☐ N Psychological Problems
- ☐ Y ☐ N Kidney Disease
- ☐ Y ☐ N Speech or Learning Disorders
- ☐ Y ☐ N Hearing Problems
- ☐ Y ☐ N Blood Transfusion
- ☐ Y ☐ N Bruise Easily
- ☐ Y ☐ N Bleeding Disorder
- ☐ Y ☐ N Kidney/Bladder Problems
- ☐ Y ☐ N Pneumonia
- ☐ Y ☐ N Heart Murmur , Heart Defect
- ☐ Y ☐ N Mitral Valve Prolapse
- ☐ Y ☐ N Heart Pacemaker
- ☐ Y ☐ N Stroke
- ☐ Y ☐ N Thyroid Problems
- ☐ Y ☐ N Cancer / Tumor or Growth
- ☐ Y ☐ N AIDS or HIV Positive

Other

- ☐ Y ☐ N See Scanned Documents: Pt Note

Additional Comments

Dental Questionnaire

List Any Dental Comments _____

Name of previous Dentist _____

Phone number of previous dentist _____

Date of last cleaning _____

Last exam date _____

Do you have current records (including xrays) from another office? _____

Has your child complained about any dental problems? _____

Any injures or surgeries to the mouth, teeth or head? _____

Does your child still take the bottle or sippy cup? _____

Does your child regularly use dental floss? _____

Do you assist your child with brushing? _____

Does your child have any sucking habits? _____

How does your child receive fluoride? _____

Child's attitude towards dentistry _____

I give permission to the following person(s) to bring my child in for dental procedures: _____

Medical Questionnaire

Medical Questionnaire

Have you had any serious illness, operation or been hospitalized within the past 5 years? _____

If Yes, what illness or problem ? _____

Are you currently taking any medication ? _____

If Yes, what ? _____

Additional Comments

Any Disease, Condition or Problem not Listed ? Please list _____

Family Physician and phone number _____

By signing below, I certify that all of the above information is true to the best of my knowledge.

_____ _____

Patient/Guardian Signature **Date**

_____ _____

Dentist Signature **Date**