Jessie Hunter, DDS

Dr. Karen Coe

CHILD'S NAME ____ NICKNAME ________________________

DATE OF BIRTH ____/_____/___ AGE _____ WEIGHT ________lbs. MALE ____ FEMALE ____

SCHOOL OR DAYCARE NAME ____

NAME OF SIBLINGS ____

NAME OF PET, FRIEND ____

SPORTS OR ACTIVITIES ____

HOW DID YOU HEAR ABOUT OUR OFFICE? ____

DENTAL HISTORY:

PURPOSE OF TODAY'S VISIT ____

DATE OF LAST EXAM _____________________ LAST X-RAYS ___________________________

ANY UNFAVORABLE DENTAL EXPERIENCES? ____

NAME OF PREVIOUS DENTIST ____

PLEASE (X) ANY WHICH APPLY TO YOUR CHILD:

_____ INJURY TO MOUTH OR TEETH Explain ____

_____ ORAL HABITS: Thumb/Finger sucking____ Pacifier____ Nail biting____ Tongue thrust____

_____ SENSITIVE/ PAINFUL TEETH Explain ____

_____ GRINDING OF TEETH: Daytime____ Nighttime____

_____ CHILD STILL NURSING? Breast____ Bottle____

FREQUENCY OF BRUSHING ___________Times per day DOES PARENT HELP? Yes ____ No ____

MEDICAL HISTORY:

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS? Circle One: Y=Yes, N=No

Y N HEART MURMUR
Y N CONGENITAL HEART DEFECT
Y N DIABETES
Y N HIV VIRUS/ AIDS
Y N BLOOD DISORDER/TRANSFUSIONS
Y N SICKLE CELL ANEMIA
Y N HEPATITIS/ JAUNDICE
Y N TUBERCULOSIS
Y N CONVULSIONS/EPILEPSY
Y N ASTHMA
Y N SINUS/ ALLERGY PROBLEMS
Y N PREMATURE BIRTH______weeks
Y N RHEUMATIC FEVER/ HIGH FEVER
Y N CANCER/ TUMORS
Y N KIDNEY/ LIVER DISEASE
Y N MENTAL HANDICAP
Y N PHYSICAL HANDICAP
Y N HEARING IMPAIRMENT
Y N SPEECH IMPAIRMENT
Y N HYPERACTIVE/ ADHD/ ADD
Y N SENSORY DISORDER
Y N AUTISM
Y N SURGERY
Y N HOSPITALIZATION

PLEASE EXPLAIN ANY "YES" ANSWERS ABOVE OR OTHER PROBLEMS NOT LISTED: _________________

____

MEDICATIONS THE CHILD IS TAKING NOW? ____

MEDICATIONS / FOOD THE CHILD IS ALLERGIC TO? ____

CHILD'S PHYSICIAN ______________________________ **PHONE** ______________

PHYSICIAN'S ADDRESS ______________________________ **DATE OF LAST EXAM** ____________

FAMILY ORTHODONTIST'S NAME ______________________________ **CITY** ______________

HAS YOUR CHILD SEEN THE ORTHODONTIST? Yes No LAST EXAM ______________________

FAMILY MEMBERS WHO SEE THE ORTHODONTIST ______________________________

EMERGENCY CONTACT (Relative or Friend not living with you) NAME ______________________________

RELATIONSHIP TO PARENT? ______________________________**PHONE** ______________________________

DENTAL INSURANCE INFORMATION:

DENTAL INSURANCE COMPANY ______________________________ ______________________________

GROUP NUMBER ______________________ **INSURANCE COMPANY PHONE** ______________________

INSURED'S NAME ______________________________ **Soc. Security or ID NUMBER** ______________________

PARENT INFORMATION:

FATHER'S NAME ______________________________**Driver's Lic #** ______________**BIRTH DATE** ___/___/___

Address ______________________________**City** __________________**State** ______**Zip**___________

Home Phone ______________________ **Cellular Phone** ____________________ **Work Phone** ______________________

Employer ______________________________ **City** ______________________________ **State** ___________

MOTHER'S NAME ______________________________ **Driver's Lic #** ______________ **BIRTH DATE** ___/___/___

Address ______________________________**City** __________________ **State** _____ **Zip** ___________

Home Phone ______________________ **Cellular Phone** ____________________ **Work Phone** ______________________

Employer ______________________________ **City** ______________________________ **State** ___________

Family email address: ____

CHILD'S PRIMARY RESIDENCE: FATHER MOTHER BOTH OTHER (See below)

If OTHER, name of caretaker and address ____

CONSENT FOR TREATMENT:

I certify that I am the parent/legal guardian of this child who is responsible for medical/dental decisions. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status at future appointments. I authorize Dr. Hunter, Dr. Coe, and staff to perform the necessary dental services for my child.

Signature ____Date ______________________