Pediatric Dental Specialties

WELCOME!

Bradley W. Wilkinson D.D.S., M.S., P.C.

Chart #__________

Child's Name_________________________________Date of Birth____________

Sex: _______Male _______Female

Medical and Dental History

Please answer all questions. This information is important for assessing your child's dental needs.

Is your child in good health? _____________
Is your child up to date with immunizations? __________
Is your child being treated for any medical condition at this time? __________
If yes, what? ____
Is your child taking any medications? __________. If yes, what? ______________________________
Has your child ever been hospitalized since birth? __________. If yes, give approximate date and reason ____
Is your child allergic to: Any medications? __________. If yes, what? __________________________
Dental anesthetics (Novacaine)? ______________________________________
Any food? __________. If yes, what? ______________________________________
Latex? ____
Other? ____

Please circle any conditions which apply to your child.

Heart Condition	Brain Injury	Fainting/Seizures/Epilepsy
Heart Murmur	Cerebral Palsy	Hyperactive/ADD
Rheumatic Fever	Spina Bifida	Depression
Artificial Heart Valves	Down's Syndrome	Blood Transfusion
Congenital Heart Defect	Autism	Surgeries/Operations
Scarlet Fever	Hearing Disorder	Seasonal Allergies
Cancer/Tumors/Leukemia	Nervous Disorder	Latex Allergy
Chemotherapy	Speech Disorder	Reflux
Respiratory Problems	Vision Disorder	Fever Blisters
Asthma	Mental Condition	Mouth Ulcers
Diabetes/Hypoglycemia	Emotional Disorder	Hemophilia
Behavioral Problems	Sickle Cell Anemia	Abnormal Bleeding
Jaw Problems/TMJ/TMD	Sickle Cell Trait	High/Low blood Pressure
Cleft Lip/Cleft Palate	Organ Problems	Hepatitis
Birth Control Pills	Tuberculosis	HIV+/AIDS/ARC

Other____

Is this your child's FIRST visit to the dentist? ___________
Does your child have a toothache or is he/she in pain or discomfort at this time? __________
Does your child require pre-medication? __________
Please circle any of the following that pertain to your child.

Grinds teeth	Bites or sucks lip	Mouth breathing/snoring
Clenches teeth	Bites nails	Sleeps with a bottle
Sucks thumb or fingers	Jaw pain	Uses "Sippy" cup
Uses a pacifier	Jaw popping	Injury to teeth, mouth, jaw or face

Parent or Guardian's Signature_____________________________Date_________

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PATIENT INFORMATION

Child's Name____
(First) (Middle) (Last)
Date of Birth______________________ Age__________ Sex _____M _____F
Street Address____
City______________________________ State_________________Zip______________
Home Phone____
Child's Physcian/Pediatrician____
School____ Grade__________
Other children in family who are patients in this office____________________________
With whom does the child live?____
Referred By____

PARENT INFORMATION

Mother's Information

Name____
Address____
City___________ST________Zip_______________
Home Phone____
Work____
Cell____
Date of Birth____
SSN____
Employer____
e-mail____

Father's Information

Name____
Address____
City___________ST________Zip_______________
Home Phone____
Work____
Cell____
Date of Birth____
SSN____
Employer____
e-mail____

Dental Insurance Information

Primary Ins.________________________________
Insurance Co. Address________________________________
____
Insurance Co. Phone________________________________
Employer________________________________
Group #________________________________
Insured's Name________________________________
Insured's DOB________________________________
Insured's SSN________________________________
Relation to patient________________________________

Secondary Ins.________________________________
Insurance Co. Address________________________________
____
Insurance Co. Phone________________________________
Employer________________________________
Group #________________________________
Insured's Name________________________________
Insured's DOB________________________________
Insured's SSN________________________________
Relation to patient________________________________

Signature **(Parent or Legal Guardian)**____**Date**__________