Child/Adolescent Medical & Dental History

NORTH GWINNETT DENTAL CARE

Date:_____

Patient's Full Name_____**Nickname**_____

Why did the child come to the dentist today? _____

Street Address_____

City_____**Zip**_____ **Patient's Main Telephone #** _____

(Mom)or (Dad)Work Telephone#_____ **Cellular Telephone #**_____

Date of Birth_____/_____/_____ **Sex: M (__) F (__) Social Security Number:**_____— _____— _____

Parent's E mail Address (important) _____ **Child's E mail Address** _____

School child attends?_____

We provide free on-site child care for our patients. Do you anticipate using this service? Yes (___) or No(___)

Do you have any additional children? Yes (__) or No (__) Names and Ages of your children:

1) _____ **2)** _____ **3)** _____ **4)** _____ **5)** _____

In case of an emergency, whom should be notified?_____**Tel.#**_____

Name of Parent (if applicable) _____**Parent Work Phone/Cellular:**_____

Occupation of parent _____ **Employer** _____

Parent's Date of Birth _____/_____/_____ **Parent's Social Security Number** _____— _____—_____

Person responsible for account (if not yourself) _____

Whom may we thank for referring you ? (___)Sign on building (___)New Homeowner Letter (___)Letter// Flyer sent to you

(___)Website (___)Friend/Family/Employee (Name: _____**) (___)Other** _____

Do you have dental insurance that may cover any part of our professional services? Yes(___) No(___)

INSURANCE INFORMATION

Insured Party's Full Name_____**Social Security Number**_____—_____—_____

Relationship to Patient: Self(___) Spouse(__) Parent / Step Parent(__) Other (specify :_____)

Employer _____ **Insurance Company Name**_____

Ins. Address _____ **Ins Phone #**_____

Group Name_____ **Group Number**_____

Secondary Insurance (if applicable)

Secondary Insurance Insured's Name _____ **Social Security Number** _____—_____—_____

Relationship to Patient: Self(___) Spouse(__) Parent/Step Parent(__) Other (specify :_____)

Employer _____ **Insurance company Name**__ _____

Ins. Address _____ **Ins Phone #** _____

Special Notes _____

Our dentists do not participate in any of the managed care dental plans (where you may only go to a dentist on a particular list). Traditional insurance is accepted and submitted on your behalf, but you are responsible for any charges your insurance does not cover at the time of service. If you do not have insurance, we have a membership plan that may make dental care more affordable. It provides two checkups per year and a fifteen percent discount off of all other dental treatment (except Botox, Fillers and Orthodontic care), for $30 per month or less (depending on size of your family). Please view our website www.SugarHillDentist.com or ask a team member for information.

Pediatrician's / Physician's Name _____**City** _____ **State**_____
Former Dentist's Name _____ **City**_____**State** _____
Why are you changing dentists?
_____
_____
Is This your child's first dental visit? (__) Y (__) N If your child is quite young we will only do as much as they are comfortable with– we want them to view this as a pleasant and fun experience. Kids usually do much better alone in the room under most circumstances—but we do allow parents to watch from the hallway (and behind the child)
When was the last time your child had a dental checkup?_____
Were X-rays taken at child's last visit? If so– what kind ? (__) BWX 4 x-rays (__) Panorex 1 large x ray (__) Don't Know
Is your child having pain today? Y(__) N(__) Please describe:
_____
Is he/she apprehensive about dental treatment Y(__) N (__) If he/she is apprehensive, what of ? (be very specific)
_____
Has your child been told to take an antibiotic before dental treatment? Y(__) N(__) Why? _____
Are you interested in straightening your child's teeth ? _____ **We offer traditional braces and INVISALIGN.**
Do your child's gums bleed when you brush? Y(__) N(__) Bleed when they floss? Y(__) N(__)
Has your child ever had any serious problems with previous dental work? Y(__) N(__) Describe: _____
Is your child allergic to any of the following

Codeine Y(_)N(_) / Dental Anesthetics Y(_) N(_) / Penicillin Y(_) N(_) / Clindamycin Y(_) N(_) / Latex Y(_) N(_)

Have you ever had any of the following diseases or medical problems? Please Circle Y or N

Y N Congenital Heart Defect
Y N Heart murmur
Y N Cerebral Palsy
Y N Tourette syndrome
Y N Mitral valve prolapse
Y N Artificial heart valve/joint
Y N Hepatitis
Y N HIV + / AIDS / ARC
Y N Tuberculosis
Y N Congenital Syndrome
Y N Mental disability

Y N Down Syndrome
Y N Diabetes
Y N Fainting or dizzy spells
Y N Growth Disorder
Y N Psychiatric treatment
Y N Anemia
Y N Blood transfusion
Y N Mouth sores
Y N Epilepsy or seizures
Y N Handicap of any sort
Y N Cortisone (steroid) medicine

Y N Sinus Trouble
Y N Rheumatic fever
Y N Jaundice
Y N Chemotherapy
Y N Radiation treatment
Y N Cancer (what kind?)
Y N _____
Y N Bulimia
Y N Asthma
Y N Hemophilia
Y N Hearing Impairment

Please list any other drugs or metals that your child is allergic to:
_____
Please list all medications/herbs/over the counter drugs your child is taking and *why* he/she is taking them.
Please list any other medical condition/ congenital abnormalities that your child has been or are currently in treatment:

1)_____ **2)**_____ **3)** _____
For_____ **For**_____ **For**_____

4)_____ **5)**_____ **6)**_____
For_____ **For**_____ **For**_____

_____
Is there a possibility your child is pregnant or taking birth control pills (__)Y (__)N
Is there any chance your child is using recreational drugs (__)Y (__)N
Does you child suck a finger/thumb or pacifier (at night or during the day (__)Y (__)N
I affirm that the information given today is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical history.

Signature of patient's Parent or Guardian:

_____**Date**_____