HENDERSONVILLE PEDIATRIC DENTISTRY
ANDREW S. MCKENZIE DDS,PA

smiles that start today & last a lifetime

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Patient Information

Date _____

Patient's Name _____ Nickname _____ Sex _____
First Middle Last

Street Address _____ Date of Birth _____ Age _____ Weight _____

Patient Social Security # __ __ __ – __ __ – __ __ __ __ Child Lives with: ❑ Both parents ❑ Mother ❑ Father ❑ Other _____

Names of brothers or sisters in practice _____ School Name _____

Patient's Physician or Pediatrician Name _____ Family Dentist _____

Whom may we thank for referring you? ❑ Media ❑ Doctor (name) _____ ❑ Friend (name) _____

❑ Website ❑ Phone Book ❑ Other _____

Responsible Party Information

❑ Single ❑ Separated

Name: _____ Marital Status: ❑ Married ❑ Divorced
First Middle Last

Residential Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security Number _____ Birthdate _____ Relationship to patient _____

Employer _____ Occupation _____ No. Years Employed _____
(if self-employed, list name of business)

Spouse's Name: _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____
(if self-employed, list name of business)

Social Security Number _____ Birthdate _____ Work Phone _____

Email Address _____ Approved ID _____ Issue Date _____

Dental Insurance Information

Policy Holder's Name _____ Policy Holder's Soc. Sec. # _____ Birthdate __/__/__

Insurance Co. _____ Group No. _____ Subscriber No. _____

Insurance Co. Address _____ Phone No. _____

Policy Holder's Employer _____ Do you have other dental insurance? ❑ Yes ❑ No

Emergency Information

Name of nearest relative not living with you _____ Phone No. _____

Address _____ Relationship to patient _____
Street City State Zip

I understand that where appropriate, credit bureau reports may be obtained.

Signed _____ Date _____

Medical History

Does your child/teen have any of the following? Please circle.

Y	N	Allergies	Y	N	Fainting	Y	N	Pregnancy/Nursing
Y	N	Anemia	Y	N	Hearing Disorder	Y	N	Rheumatic Fever
Y	N	Asthma	Y	N	Heart Disease	Y	N	Seizures/Epilepsy
Y	N	Autism	Y	N	Hepatitis	Y	N	Special Needs
Y	N	Bleeding Disorder	Y	N	Kidney or Liver Disease	Y	N	Speech Disorder
Y	N	Diabetes	Y	N	Mental Disorder	Y	N	AIDS/HIV
Y	N	Cold/Virus	Y	N	Nervous Disorder	Y	N	Other_____

My child was born: (please check) ❑ Less than 35 weeks ❑ 35–40 weeks ❑ 40+ gestation

Did you experience any problems during your pregnancy? ❑ Yes ❑ No If Yes, please describe:_____

_____

Do any family members smoke around your child? ❑ Yes ❑ No

Has your child experienced any other physical or mental disorder that is not listed above? ❑ Yes ❑ No

If Yes, please describe:_____

Has any immediate family member had any of the above? ❑ Yes ❑ No If Yes, please describe: _____

_____

Is your child allergic to any of the following drugs:

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs: ❑ Yes ❑ No If Yes, please list: _____

Is your child allergic to Latex, red dye or anything we need to be aware of? ❑ Yes ❑ No If Yes, list: _____

_____

Is your child presently under the care of a physician for any illness? ❑ Yes ❑ No If Yes, please list:_____

_____

List any drugs or medicines presently being taken: _____

Has your child ever been hospitalized? ❑ Yes ❑ No If Yes, please give reason and date(s) _____

_____

Dental History

Do you want complete treatment for your child? ❑ Yes ❑ No

Why did you bring your child to see us today? _____

Is this your child's first visit to the dentist? ❑ Yes ❑ No Name of previous dentist: _____

Has your child ever had a serious/difficult problem associated with previous dental work? ❑ Yes ❑ No

If Yes, please explain_____

Date of last dental visit _____ For what service _____

Were any x-rays taken? ❑ Yes ❑ No If Yes, have x-rays been sent to our office?_____

How do you expect your child to behave in our office?_____

Y N Does your child brush his/her teeth daily?

Y N Do you assist child with tooth brushing?

Y N Is dental floss used? — How often?_____

Y N Is fluoride taken in any form? How: Y N – Vitamins Y N – Toothpaste Y N – Drinking Water

Y N Any mouth habits (thumbsucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)

Y N Any injuries to mouth, teeth, head? Date(s)_____

Y N Has child ever had jaw joint pain or tenderness?

My child uses a bottle (please check one): ❑ no ❑ daytime ❑ nighttime.

My child uses a sippy cup (please check one): ❑ no ❑ daytime ❑ nighttime.

May we request release of your child's medical records? ❑ Yes ❑ No

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here: _____

_____

I give my consent to needed dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name) _____ . I accept responsibility for payment of services rendered.

Signed:_____ Date: _____

(Parent or Guardian)

Office use only: Doctor's Comments:_____

_____