Nashville Pediatric Dentistry
130 Seaboard Ln Suite #A1
Franklin, TN 37067

Date_____

1. Patient Information

Child's Name _____

Goes by: _____ Male Female

Child's Birthdate ____/____/____

Child's Home Address:_____

_____

2. Who may we thank for referring you

_____

3. Mother's Information

Name_____

Birthdate ____/____/____ SS # _____

Cell Phone # (_____)_____

Work # (_____)_____ Ext. _____

Email Address:_____

Marital Status: Married Single Divorce d
Separated Widowed

4. Father's Information

Name_____

Birthdate ____/____/____ SS # _____

Cell Phone # (_____)_____

Work # (_____)_____ Ext. _____

Email Address:_____

Marital Status: Married Single Divorce d
Separated Widowed

5. Who is Accompanying the Child Today?

Name _____

Do you have legal custody of this child? Yes No

6. Primary Dental Insurance

Insurance Co. Name _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

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7. Medical History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Allergies to Latex Product
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Autism
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver
Y N Pregnancy
Y N Rheumatic/Scarlet Fever
Y N Sensory Issues
Y N Tuberculosis

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking _____

_____

Please list all drugs the child is allergic to _____

_____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

I understand that the information I have given is correct to the best of my knowledge, that it will be held in confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____

Signature of Parent or Guardian Relationship to Patient Date

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

For Office Use Only

Dr. Initials _____ Date _____