

SOCIAL AND HEALTH HISTORY

This record is confidential and for use only within this office.



I. PATIENT INFORMATION

Patient Name _____ Preferred Name _____ Age _____

Sex _____ Race _____ Date of Birth _____ School _____ Grade _____

Patient's Address _____
Street City State Zip

Home Phone _____ **Cell Phone** _____ **E-Mail** _____

Names of Siblings _____ Hobbies and Pets _____

Do Mother, Father and Children live together? _____ Yes _____ No If "No," with whom does child live? _____

Name of Relative or Friend _____ Phone _____

II. PARENTAL INFORMATION

Mother's Name _____ Date of Birth _____ S.S. # _____

Her Address _____ Home Phone _____
Street City State Zip

Where Employed _____ Work Phone _____

Father's Name _____ Date of Birth _____ S.S. # _____

His Address _____ Home Phone _____
Street City State Zip

Where Employed _____ Work Phone _____

III. DENTAL INSURANCE

Subscriber Name _____ ID # _____ Date of Birth _____

Insurance Name _____ Phone # _____

Address _____ Policy/Group # _____

Method of Payment Accepted: **Cash** **Checks/Debit Cards** **Visa/MasterCard**

Phone Numbers for Confirmation of Appointment _____

Whom may we thank for your referral to our office? _____

IV. AUTHORIZATION TO TREAT

I, being the parent or guardian of the above minor patient, hereby do authorize and request the performance of dental services for this patient and the use of whatever procedures Dr. Townsend Brown, Jr. may deem necessary during treatment.

I understand that Dr. Brown and such assistants as he may designate to treat the above-mentioned patient will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by Dr. Brown.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology.

I grant permission to use clinical photographs in scientific journals and lectures.

I accept responsibility for full payment of all dental services performed on the above-named patient. The parent, or guardian, bringing the patient to our office is responsible for payment of the account. Insurance co-payments are due at the time of service. The insurance will be filed promptly, but the remaining account balance must be paid in full within 30 days, regardless of whether the insurance company has paid or not. Delinquent accounts over 60 days will incur 1 1/2% per month finance charge. If the account is referred for collection, the parent, or guardian, will be responsible for the balance plus the attorney's fee which is 25% of the remaining balance.

Signature of parent or guardian

Date

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

V. MEDICAL HISTORY

| YES | NO | | YES | NO | | YES | NO | | YES | NO | |
|-------|-------|--------------------------|-------|-------|--------------------|-------|-------|-------------------------|-------|-------|-----------------------|
| _____ | _____ | Adrenal Disorders | _____ | _____ | Convulsions | _____ | _____ | Heart Condition | _____ | _____ | Nose/Throat Disorders |
| _____ | _____ | Anemic | _____ | _____ | Diabetes | _____ | _____ | Hemophilia | _____ | _____ | Rheumatic Fever |
| _____ | _____ | Asthma | _____ | _____ | Emotional Problems | _____ | _____ | Hepatitis | _____ | _____ | Skin Disorders |
| _____ | _____ | Auto-Immune Deficiency | _____ | _____ | Epilepsy | _____ | _____ | HIV-Positive (AIDS/ARC) | _____ | _____ | Speech Problems |
| _____ | _____ | Blood Disorders | _____ | _____ | Ear Disorders | _____ | _____ | Kidney Disorders | _____ | _____ | Thyroid Disorders |
| _____ | _____ | Brain Disorders | _____ | _____ | Excessive Bleeding | _____ | _____ | Liver Disease | _____ | _____ | Tumors |
| _____ | _____ | Cleft Lip / Cleft Palate | _____ | _____ | Eye Disorders | _____ | _____ | Muscle Disorders | _____ | _____ | Others _____ |

Is your child allergic to any medicine or food? YES_____ NO_____ If "Yes," What? _____

Is your child taking any medicine now? YES_____ NO_____ If "Yes," What? _____

Has your child ever been hospitalized? YES_____ NO_____ If "Yes," What? _____

Has your child had to make an emergency visit to a physician or the emergency room in the last 6 months? YES_____ NO_____

If "Yes," when and for what condition? _____

How long since your child's last physical examination? _____

How long since his/her last tetanus shot? _____

Name and address of child's physician? _____

Is your child: Advanced _____ Progressing Normally _____ A Slow Learner _____ Hyperactive _____

Is there anything else about your child that you think I should know in order to better plan his/her dental treatment? _____

Comments _____

VI. DENTAL HISTORY

YES NO

_____ Is this your child's first visit to the dentist?

_____ Has your child had a toothache recently?

_____ Has your child had dental radiographs (x-rays) taken? Bitewings_____ Panorex_____

_____ Does your child suck his/her finger, thumb or lip? (If yes, underline)

_____ Is your child taking any vitamins or fluorides?

At what age did your child stop using a nursing bottle? _____

How often are your child's teeth brushed? _____

Who brushes your child's teeth? _____

What type of toothpaste does your child use? _____

Does your family drink well or city water? _____

Dentist Previously Seen _____

Does your child have a dental problem in which you are especially concerned? (If yes, what is the problem?)

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.