PATIENT HISTORY FORM

Charlie Coulter, DDS
Jerry Casper, DMD
PEDIATRIC DENTISTRY

Patient Information

Patient Name: _____
Preferred Name: _____
Age: _____ Gender: M / F Date of Birth _____

Address: _____
City_____ State_____ Zip_____

Referred by: _____

Is this your child's first dental visit? If no, when was the last visit?

_____

Do you have well water at home? _____
Has your child bumped any teeth? If so, when? _____

Has your child had history of headaches, popping, or clicking of the jaw? _____
Does your child still have a nighttime bottle? _____
Does your child have a toothache? If so, how long? ____

Does your child have any of the following habits? Please indicate how long and if it is an active habit.
Thumb Sucking: _____
Finger Habit: _____
Pacifier: _____

How often does your child brush? _____
Are they supervised and by whom? _____
Is dental floss used? _____

Does your child receive:

- ☐ Fluoride tablets/drops
- ☐ Fluoridated water
- ☐ Fluoride in vitamins
- ☐ Bottled water
- ☐ Well water

Please list any siblings to the patient listed above that will be attending our practice: _____

_____

Emergency Contact

Name/Relationship: _____
Phone Number: _____

Responsible Party Information

Names of Legal Guardians and relationship:
1._____
Relationship: _____
2._____
Relationship: _____

Address if different than the Patient's listed to the left:

_____

_____

Preferred Phone number for confirmations:
Home or Cell (circle one):

_____

Other Number:

_____

Email address for confirmations (confidential):

_____

Financial Information

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees and applicable court costs in addition to my outstanding balance. I hereby authorize payment directly to D4C Dental Brands Inc., its affiliated practices, subsidiaries, parent companies, (together the "company"), the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

SIGNATURE: _____

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Patient Medical History

Family Physician's Name: _____
_____
Address: _____
Phone Number: _____

Is your child under the care of a physician for other than routine care? Explain. _____
_____

Please list any **drug** allergies your child may have: ____
_____
_____

Please list any **other** allergies your child may have: ____
_____
_____

Please list any medications your child is currently taking, daily/as needed, prescription or over the counter and why:
_____
_____
_____

Has your child ever been hospitalized or had surgery for any reason, including emergency or scheduled treatment, please list when and for what reason: _____
_____
_____
_____

Has your child been diagnosed with any emotional, intellectual, mental, nervous, or behavioral disorders? Please explain. _____
_____
_____

Please list any specialists, outside of your family physician, that your child sees. Please include their office and contact information: _____
_____

Please indicate if your child has been diagnosed with any of the following conditions:

- ☐ ADD / ADHD
- ☐ Anemia / Sickle Cell Anemia
- ☐ Asthma / Reactive Airway
- ☐ Autism
- ☐ Bleeding or Blood Disorder
- ☐ Cerebral Palsy
- ☐ Cleft Lip / Palate
- ☐ Diabetes
- ☐ Dizziness / Fainting
- ☐ Endocrine Disorder
- ☐ Epilepsy / Seizures
- ☐ Heart Condition
- ☐ Hepatitis / Liver Problems
- ☐ H.I.V
- ☐ Malignancies / Cancer / Leukemia
- ☐ Pregnancy
- ☐ Positive TB Test
- ☐ Stomach / Intestinal Disorder
- ☐ Other: _____

Please explain any conditions checked above so that we can treat your child safely. _____
_____
_____
_____
_____

Photo Release

I hereby authorize of D4C Dental Brands Inc., its affiliated practices, subsidiaries, parent companies, (together the "company") and all company employees, associates and contractors, use and/or publish still or video photography of _____ (patient name) on printed materials or in electronic formats, including on the internet for the purpose of promoting or advertising the company. In giving this consent I release the advertising department of the company from liability for any violation or any personal proprietary right I may have in connection with such sale, reproduction, use or compensation.

SIGNATURE: _____

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia and routine dental treatment with use of proper and acceptable methods to complete the same. I accept responsibility for payment of services rendered for my child, _____. I understand I will be informed of any treatment other than routine dental treatment before it is performed.

SIGNATURE OF LEGAL GUARDIAN: _____ DATE: _____