**Ben Taylor, D.D.S.**
**Brandy Loving, D.D.S.**

# PATIENT HISTORY

**Pediatric Dentistry**

In order to assure your child's safety, comfort and happiness during dental treatment, we need to obtain information from you. Please carefully and completely answer the questions below. THANK YOU.

**PRINT:**

Child's Name_____Nickname (if any)_____
First Middle Last

Date Of Birth_____Age_____Sex: M F
Month Day Year

Attends what school? _____Grade_____
Brothers and Sisters:

_____ _____ _____ _____
Name Age Name Age

_____ _____ _____ _____
Name Age Name Age

Pets_____
Kind and Name

Interests or hobbies_____

## DENTAL HISTORY

Why did you make this appointment? _____
_____

Is this your child's first visit to a dentist? Yes No
If not, how long since the last dental visit? _____
Child's previous dentist:
Name_____
Address_____
Approximate date of last dental "X-Rays"_____

Does your child currently have any dental problems or has your child ever had any major dental problems in the past? Yes No
If so, please explain_____

Has your child ever had any unpleasant dental experience? Yes No
If so, please explain_____

## FAMILY DENTAL HISTORY

Do any dental problems run in your family? Yes No
If so, please explain _____

Please rank the following family members' decay history:
Mother (past or present cavities): Many Average Few None
Father (past or present cavities): Many Average Few None
Siblings (brothers or sisters): Many Average Few None

## CAVITY PREVENTION HISTORY

Does your child receive fluoride daily?
Yes We have it in our water
Yes Our child swallows a fluoride supplement daily
No We do not have fluoride in our water or give supplements

Does your child …
Use a toothpaste containing fluoride? Yes No
Use other fluoride products (gels or rinses) Yes No

How often are your child's teeth brushed daily? 1 2 More

Who brushes your child's teeth? Child parent we take turns other_____

Is your child familiar with dental floss? Yes No

## GROWTH AND DEVELOPMENT

Does your child have a bite problem? Yes No
Does your child have a speech problem? Yes No
Does your child have any oral habits such as sucking a thumb, finger, pacifier, or lip, nail biting, grinding, etc.? Yes No

## MEDICAL HISTORY

Child's Physician:
Name_____
Address_____
Phone Number_____

Does your child have regular medical examinations? Yes No

Is your child currently under a physician's care for any reason? Yes No

Has your child had any surgery, serious illness, or accident in the past? Yes No
If so, please explain_____

Is any future surgery or medical treatment planned at this time? Yes No
If so, please explain_____

Has your child had any history of:
Heart Trouble or Murmur Yes No
Rheumatic Fever Yes No
Diabetes Yes No
Kidney or Liver Disease Yes No
Epilepsy or Nervous System Disorder Yes No
Tuberculosis Yes No
Asthma or Lung Problems Yes No
Bleeding Trouble or Blood Transfusions Yes No
Aids, Hepatitis, or Cancer Yes No

Does your child have any mental, emotional, or physical Delay or condition? Yes No
If so, please describe_____

Is your child allergic to any medications or drugs? Yes No
If so, please list_____

Is your child currently taking any medications? Yes No
If so, please explain_____

**PLEASE PRINT** **Date**_____

**FATHER:** Name_____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Home Address Street_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Other Phone_____
Occupation_____ Employer_____

**MOTHER:** Name_____
Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed
Home Address Street_____
City_____ State_____ Zip_____
Home Phone_____ Work Phone_____
Cell Phone_____ Other Phone_____
Occupation_____ Employer_____

Does your child reside with both parents? _____ If not then who is custodial guardian? _____

Permission is hereby granted to the doctor and staff to perform a dental examination including necessary x-rays, preventive education, and preventive procedures such as fluoride treatment and dental cleaning.
Signature_____Date_____

Who is financially responsible for this child's account? _____

Is your child's dental care covered by a dental insurance program? ☐ Yes ☐ No
If so, please complete the following:
Is your child is covered by more then one dental program? ☐ Yes ☐ No

| If so, please write both below: | First Insurance | Second Insurance |
|---|---|---|
| Subscriber (covered employee) | | |
| Employer providing insurance | | |
| Name of insurance carrier (company) | | |
| Insurance ID number | | |
| Social Security number | | |
| Date of Birth | | |

How did you find out about our office?

☐ Referred by physician or dentist ☐ Referred by friend ☐ Phone Book ☐ Another child in the family ☐ Other

Who may we thank for referring you to our office?

Name_____ Address_____

Please indicate account preference:

☐ I desire to pay at each visit for services rendered.
☐ I prefer to pay my estimated portion of each visit and assign insurance payments to Dr. Taylor.

Our office gives you an estimate of charges; actual charges may differ due to conditions found during treatment. Please remember we accept insurance assignment as a courtesy to you. If your insurance company pays less than the estimated amount or does not pay within 60 days you will be billed for the balance. A 40% fee is charged for accounts turned over to collection (minimum $20).