



Vinings Center for Dentistry

Welcome! How did you learn of our practice? _____ **Thank you for choosing us.**

Child's Full Name: _____		<input type="checkbox"/> M <input type="checkbox"/> F	Child lives with: _____	
Date of Birth: _____	Age: _____	Grade: _____	School: _____	

Mother/ Female Guardian: _____ Father/ Male Guardian: _____

Full name: _____ Spouse name: _____

Address: _____ Address: _____

City/State: _____ Zip: _____ City/State: _____ Zip: _____

(Hm): _____ (Hm): _____

(Wk): _____ Ext. _____ (Wk): _____ Ext. _____

(Cell): _____ (Cell): _____

E-Mail Address: _____ E-Mail Address: _____

Date of Birth: _____ Age: _____ Sex: _____ Date of Birth: _____ Age: _____ Sex: _____

Social Security No.: _____ Social Security No.: _____

Occupation: _____ Marital Status: M S D Occupation: _____

Employer: _____ Employer: _____

Employer address: _____ Employer address: _____

Do you have dental insurance? Yes No Does your spouse have dental insurance? Yes No

Insurance company name: _____ Insurance company name: _____

If dual insurance coverage, your insurance is Primary Secondary

Payment method you prefer: Cash or Check Visa / MasterCard / AMEX ** See payment policy*

CHILD MEDICAL AND DENTAL HISTORY

Does your child now have or in the past had a history of any of the following: (Answer all questions)

	Yes	No		Yes	No		Yes	No
Heart problems or disease			Toothaches			Allergic to Penicillin		
First dental visit			Autism			Allergic to aspirin		
Unhappy dental experiences			Heart murmur			Bad reaction to "Novocaine"		
Sexual / physical abuse?			Attention Deficit Disorder			Allergic to sulfa drugs		
Behavioral / disciplinary problems?			Rheumatic fever			Allergic to Codeine		
Kidney disease			Immune deficiency			Food / Environmental Allergies?		
Stomach or GI disorder			Respiratory/lung disease			Child taking Ritalin or ADD drug?		
Diabetes			Epilepsy / Seizure disorder			Taking medicine now?		
Ear tubes			Cancer/Tumors			Eating disorder		
Sinusitis, Hay fever			HIV positive or AIDS			Latex allergy		
Asthma			Herpes			Is Parent anxious about dentistry?		

Is child allergic to or ever had an unfavorable reaction to any drug(s)? Yes No What drug? _____

List any medicines child is now taking: 1) _____ 2) _____ 3) _____

4) _____ 5) _____ 6) _____ 7) _____

Is the child being treated by a physician now? Yes No For what condition? _____

Name of child's Pediatrician / Physician: _____ Telephone: _____ Last visit date: _____

Name of child's previous Dentist: _____ Telephone: _____ Last visit date: _____

Is there any additional information we should know before treatment is begun on the child? _____

The main reason you have come to this dental visit today? _____

Date

Signature

RESPONSIBILITY OF CONSENT STATEMENT

I hereby authorize and request the performance of dental services for my minor child _____ (name). I give my consent, as an adult, for my child, to any advisable and necessary dental procedures, medications, or anesthetics administered by Dr. Lumpkin, attending dentist or by supervised staff of the Vinings Center for Dentistry, PC for diagnostic purposes and dental treatment. I have answered all health history questions and disclosed any information that would be needed in the treatment of my child truthfully and thoroughly to the best of my ability and knowledge.

Date

Signature

BROKEN APPOINTMENT FEE:

There is a \$45.00 fee for all appointments missed or cancelled without 24 hour notice.

Initials:

HISTORY REVIEW (DOCTOR'S NOTES)