

CHARLES H. CRAWFORD, JR., D.M.D., P.A.
PEDIATRIC AND ADOLESCENT DENTISTRY
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THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name _____ Preferred Name _____ Age _____
Sex _____ Race _____ Date of Birth _____ Place of Birth _____
Patient's Address _____ Home Phone _____
Street City State Zip

Father's Name _____ Date of Birth _____ Social Security # _____
His Address _____ Phone _____
Street City State Zip

Employer _____ Address _____ Phone _____
Father's Dental Insurance _____
Company Address Policy #

Mother's Name _____ Date of Birth _____ Social Security # _____
Her Address _____ Phone _____
Street City State Zip

Employer _____ Address _____ Phone _____
Mother's Dental Insurance _____
Company Address Policy #

Phone Numbers for confirmation of appointment _____ E-mail Address _____

With whom does patient live? _____

Other children in family – names and ages _____

Medicaid? Yes ___ No ___ Children's Special Health Services _____ Other _____

Child's Physician _____ Family Dentist _____

Whom may we thank for referring you to our office? Doctor Parent Patient _____
Name of person referring patient

Address – Street or RFD City State Zip

HEALTH HISTORY

	Yes	No	Check any of the following that may pertain to your child		
Is your child in good health?	___	___	___ Heart condition	___ Liver Problem	___ HIV
Does your child have regular medical exams?	___	___	___ Lung problem	___ Tuberculosis	___ AIDS
Is your child up to date with immunizations?	___	___	___ Brain injury	___ Retardation	___ Asthma
Is your child presently taking medicine?	___	___	___ Kidney Problem	___ Cerebral palsy	___ Autism
If so, what _____			___ Vision Disorder	___ Hepatitis	___ Diabetes
Has your child experienced any unfavorable reaction to medicine?	___	___	___ Emotional Disorder	___ Mental Disorder	___ Allergies
If so, what _____			___ Sickle Cell Anemia	___ Down's Syndrome	___ Epilepsy
Is your child presently undergoing medical treatment?	___	___	___ Bleeding Disorder	___ Speech Disorder	___ Heart Murmur
If so, what _____			___ Hearing Disorder	___ Nervous Disorder	
Has your child been hospitalized since birth?	___	___			
Date _____ Reason _____			___ Other _____		
List any infectious diseases _____					

What is your water source? Private well? Public System? Name of System _____

	Yes	No		Yes	No
Is this your child's first dental visit?	___	___	Is your child a fingersucker?	___	___
If not, date of last dental care _____			Does your child use a pacifier?	___	___
Has your child had an unfavorable experience in a dental office?	___	___	Was your child bottle fed?	___	___
Does your child have a toothache?	___	___	Age discontinued _____		
Purpose of this appointment _____			Was your child breastfed?	___	___
			Age discontinued _____		

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment:

I agree to diagnostic procedures and dental treatments as found necessary and desirable by Charles H. Crawford, Jr., D.M.D., P.A. for the patient named above. I do also authorize and request the administration of such anesthetics and/or sedatives as may be deemed advisable by the above named doctor. (You will be informed of all services before any treatment is rendered for your child.) I will accept responsibility for this account should named responsible party fail or insurance benefit be denied.

Date: _____

Signature of person legally responsible