

# Welcome

Britt D. Vinson D.D.S., M.S.D.

Date: \_\_\_\_\_

## TELL US ABOUT YOUR CHILD

Name: \_\_\_\_\_  
Last First Middle

Likes to be called \_\_\_\_\_

Male  Female

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_

City State Zip

Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Hobbies/ Interests: \_\_\_\_\_

Siblings and ages: \_\_\_\_\_

Family Dentist: \_\_\_\_\_

Parents' Marital Status

Single  Married  Divorced  Widowed  Separated

Who will be responsible for the bill?  Mother  Father  Both

If both, will it be equal responsibility?  Yes  No

If No, please explain \_\_\_\_\_

List any family members that have been treated by this office: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Referred By: \_\_\_\_\_

## Mother's Information

Name: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_  
Street Apt/ Condo

City State Zip

Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ ext. \_\_\_\_\_

Cell phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Does Mother have legal custody of this child?  Yes  No

Email Address: \_\_\_\_\_

## Father's Information

Name: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_  
Street Apt/Condo

City State Zip

Home Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

SSN: \_\_\_\_\_

Employer: \_\_\_\_\_

Occupation: \_\_\_\_\_

Work Telephone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Does Father have legal custody of this child?  Yes  No

Email Address: \_\_\_\_\_

(Over)

# Medical History

Physician's Name: \_\_\_\_\_

Is your child taking any medications (include over-the-counter) \_\_\_\_\_ yes \_\_\_\_\_ no

Date of last visit \_\_\_\_\_ Please list each drug: \_\_\_\_\_

Current health is: \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor

## Does your child have a history of any of the following? (Please circle)

Abnormal Bleeding	Blood disorders	Epilepsy/Seizures	Mitral Valve Problems	Sinus Problems
Anemia	Blood Transfusions	Heart Disorders	Psychiatric Problems	Surgery
Acquired Immune Disorder	Cancer	Hospitalization	Radiation Treatment	Tuberculosis
Arthritis	Diabetes	Kidney Disorders	Rheumatic Fever	Ulcers/Colitis
Artificial Joints or valves	Difficulty Breathing	Lung Disorders	Scarlet Fever	Vision/Hearing
Asthma	Drug/ Alcohol Abuse	Migraines	Seasonal Allergies	

Other Medial problems: \_\_\_\_\_

Please explain any circled responses: \_\_\_\_\_

Have adenoid and/ or tonsils been removed? \_\_\_\_\_ yes \_\_\_\_\_ No If so, when? \_\_\_\_\_

In order to gauge growth, has puberty begun? \_\_\_\_\_ yes \_\_\_\_\_ No Girls: Has menstruation begun? \_\_\_\_\_ yes \_\_\_\_\_ No

## Is your child allergic to any of the following? (Please Circle)

Anesthetics	Aspirin	Amoxicillin	Codeine	Cyclosporins	Erythromycin	Latex	Metal
Penicillin	Sulfa Drugs	Tetracycline	Other				

Please list any other drugs or material your child may be allergic to: \_\_\_\_\_

# Dental History

Dentist Name: \_\_\_\_\_

Date of last visit: \_\_\_\_\_

## (Circle all that apply)

Complication following dental treatment      Toothaches or cavities at present      Uses any type of fluoride products

Clicking /popping jaw pain      Inherited any family or dental problems      Grind/clench teeth day or night

Ever injured teeth      Injured face or jaw      Sucked fingers or thumb

Needs to be pre-medicated before dental treatment      Tonsils or adenoids removed

Please explain any circled item(s) from above: \_\_\_\_\_

Realizing that successful treatment greatly depends upon the patient's cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restrictions, handicaps, or problems that might be encountered during treatment?

Yes \_\_\_\_\_ No \_\_\_\_\_ if yes, please explain: \_\_\_\_\_

PERSON COMPLETING THIS FORM:

Signature: \_\_\_\_\_ Relationship To Patient: \_\_\_\_\_