

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: _____ Employer: _____

School: _____ Grade: _____ Occupation: _____

Address: _____ apt/condo
Work Telephone: (____) _____ - _____ ext.____

City State Zip

Home Telephone: (____) _____ - _____

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:

Mother's Information

Name: _____
Last First

Address: _____
Street Apt/ Condo

City State Zip

Home Telephone: (____) _____ - _____

SSN: _____

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

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 choose all that apply)

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 choose all that apply)

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: _____

(Choose 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: _____