15-Year Anniversary
WHISPERING PINES DENTAL
WILLIAM G. ROBISON, DDS

PATIENT HISTORY RECORD

_____
FIRST NAME MIDDLE LAST NAME NICKNAME

AGE_____ DATE OF BIRTH_____ MALE_____FEMALE_____ HOME PHONE_____

HOME ADDRESS_____CITY_____ZIP_____

E-MAIL ADDRESS_____
Whom may we thank
for referring you?_____CHILD'S SCHOOL_____GRADE_____

FIRST NAMES OF THE CHILD'S SIBLINGS: _____

DENTAL HISTORY:

☐Y N Is this your child's first visit to the dentist? If not, approximate date of child's last visit_____
_____

☐Y N☐ Is your child's water fluoridated?
☐Y N☐ Is your child taking any fluoride supplements?
☐Y N☐ Has your child ever had any jaw pain or tenderness?
☐Y N☐ Does your child brush their teeth daily?
☐Y N☐ Does your child floss their teeth daily?

Does your child have any of the following habits?

☐Y N☐ Finger or thumb sucking / pacifier
☐Y N☐ Grinding / Bruxism
☐Y N☐ Nail biting
☐Y N☐ Mouth breathing
☐Y N☐ Nursing bottle habits / breast-feeding

ARE THERE ANY OTHER CONCERNS YOU WOULD LIKE TO BRING TO OUR ATTENTION?

_____
_____

MEDICAL HISTORY:

Height _____Weight _____
Child's Physician_____
Family Dentist_____
Phone #_____Date of last visit_____
Child's current physical health:
Good _____Fair _____Poor _____

Please list all medications your child is currently taking:

_____
_____
_____

MEDICAL HISTORY CONTINUED:

Has your child ever had any of the following medical problems?

☐Y N☐ Blood Transfusion
☐Y N☐ Cerebral Palsy
☐Y N☐ Heart Murmur
☐Y N☐ Cancer / Tumors
☐Y N☐ Diabetes
☐Y N☐ Rheumatic Fever
☐Y N☐ HIV+/AIDS
☐Y N☐ Anemia / Blood Disorders
☐Y N☐ Asthma / Breathing Problems
☐Y N☐ Hepatitis / Jaundice
☐Y N☐ Tuberculosis (TB)
☐Y N☐ Congenital Heart Defect
☐Y N☐ Seizures / Epilepsy
☐Y N☐ Abnormal Bleeding
☐Y N☐ Hearing Impairments
☐Y N☐ Any Operations
Please explain:_____
☐Y N☐ Any hospital stays
Please explain:_____
☐Y N☐ Kidney / Liver problems
☐Y N☐ Handicaps / Disabilities / Special Needs
Please explain:_____
☐Y N☐ Allergies to any drugs
☐Y N☐ Latex Allergy
☐Y N☐ Food Allergies

Please list all medications your child is allergic to:

_____

Please discuss any medical conditions your child has:

_____

MOTHER'S INFORMATION

Mother's name_____
SS #_____-_____-_____ Birth date_____
Address (if different)_____
_____
Home phone_____
Work phone_____
Cell phone_____
Occupation_____
Employer_____
Employer's address_____

FATHER'S INFORMATION

Father's name_____
SS #_____-_____-_____Birth date_____
Address (if different)_____
_____
Home phone_____
Work phone_____
Cell phone_____
Occupation_____
Employer_____
Employer's address_____

DENTAL INSURANCE INFORMATION

Name of 1st Insurance_____ Group #_____
Subscriber Name_____ DOB_____SS#_____-_____-_____
Employer_____ Phone #_____ Address_____
Relationship to child: mother☐ father☐ step-mother☐ step-father☐ guardian☐ other☐

Name of 2nd Insurance_____ Group # _____
Subscriber Name _____ DOB_____SS# _____-_____-_____
Employer_____Phone #_____ Address_____
Relationship to child: mother☐ father☐ step-mother☐ step-father☐ guardian☐ other☐

Emergency Contact: (list someone who does not live in household)
Name_____ Phone #_____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT _____
Address (if different)_____ Home Phone_____ Work Phone_____

CONSENT FOR DENTAL TREATMENT:

Before any dental procedures are performed including radiographs, diagnostic aids, local/topical anesthesia, nitrous oxide, oral sedation or general this signed permission statement must be obtained from the parent/guardian. Some risks and complications are known to be associated with dental procedures, although their occurrence is not frequent. The most common complications associated with pediatric dental treatment include: nausea the administration of topical fluoride rinses, biting tongue/lip following the administration of local anesthesia. Less common complications include numbness, infection, prolonged bleeding, discoloration, vomiting and injury to nerves near treatment site, fracture of tooth root, which may require surgery for removal. Children with HEART disease are required to take antibiotics before and following dental treatment to minimize the risk of s bacterial endocarditis (heart infection). You, the parent/guardian, will be informed of ALL dental services and fees for services BEFORE any are r your child.

I hereby certify that the foregoing information is correct and that I have read and understand this consent form.

Signature of Parent or Guardian_____Date_____

History Update: The parent or guardian who accompanies the child at each visit is responsible for payment at the time of service unless prior arrangements have been approved.
I have reviewed my child's health history and it is correct.

DATE_____SIGNATURE_____COMMENTS_____
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