DEBORAH A. ASHCRAFT, DMD, PC

PEDIATRIC AND ADOLESCENT DENTISTRY

460 W. Martintown Rd. • North Augusta, SC 29841 • 803-279-9901 • Fax 803-279-9215

Medical and Dental History *(Please print clearly and fill out completely!)*

Child's name: (LAST)_____(FIRST)_____(MIDDLE) _____

Name child goes by:_____ Gender: M / F Race:_____ Birthdate:_____ Age: ____ Grade:_____ School:_____

Address: _____ (CITY)_____(STATE)_____ (ZIP)_____

Names and ages of other children in family:_____

Do both parents live together? ❑ Yes ❑ No If not, with whom does the child live?_____

Dental Insurance? ❑ Yes ❑ No Plan Name/Number:_____ **Subscriber/SSN:** _____

Person financially responsible for account:_____

Father's Name: _____**DOB:**_____ **SSN:**_____

Address if different from child's:_____ **Home Phone:** ( ) _____

Drivers Lic.#/State:_____ **Cell Phone:** ( )_____

Employer/Department:_____Work Phone: ( ) _____

Mother's Name: _____**DOB:**_____ **SSN:** _____

Address if different from child's:_____ **Home Phone:** ( ) _____

Drivers Lic.#/State:_____ **Cell Phone:** ( )_____

Employer/Department:_____Work Phone: ( ) _____

Alternate contact person(s)/phone number(s): Name_____ Phone: ( ) _____

Name_____ Phone: ( )_____

Whom may we thank for referring you?_____

Medical Conditions: CHECK if your child presently has or previously had & INITIAL

❑ AIDS	❑ Cerebral palsy	❑ High blood pressure	❑ Muscle disorder
❑ Anemia	❑ Convulsions	❑ HIV-positive	❑ Nose/throat disorder
❑ Asthma	❑ Diabetes	❑ Hormone disorder	❑ Prolonged illness
❑ Bleeding tendency	❑ Ear disorders	❑ Hyperactivity	❑ Rheumatic fever
❑ Blood disease	❑ Epilepsy	❑ Jaundice	❑ Skin disorder
❑ Blood transfusion	❑ Eye disorders	❑ Kidney disease	❑ Speech problem
❑ Bone disorder	❑ Fainting	❑ Liver disease	❑ Stomach problem
❑ Brain disorder	❑ Heart condition	❑ Lung disease	❑ Tubes in Ear
❑ Cancer or tumors	❑ Hemophilia	❑ Mental retardation	**INITIALS**_____

Child's Physician: (NAME):_____(PHONE): (_____) _____

❑ No ❑ Yes Does your child have any other medical condition? _____

❑ **No** ❑ **Yes** **Is your child taking any medicine? (LIST)** _____

❑ **No** ❑ **Yes** **Is you child allergic to any medicine or food? (LIST)** _____

❑ **No** ❑ **Yes** **Has your child ever been hospitalized?** _____

❑ No ❑ Yes Is this your child's first visit to the dentist? **Date of last dental visit** _____

❑ **No** ❑ **Yes** **Were there any problems with previous dental treatment?** _____

❑ No ❑ Yes Is your child using fluoride tablets, drops or rinses? _____

❑ No ❑ Yes Has your child recently had a toothache? _____

❑ No ❑ Yes Does your child suck a thumb, finger or have any other oral habit? _____

❑ No ❑ Yes Has your child ever injured his/her teeth or jaws?_____

❑ No ❑ Yes Does your child have a dental condition about which you are especially concerned? _____

_____

How often are your child's teeth brushed?_____ By whom?_____

What is the source of your child's drinking water? ❑ Public water ❑ Well water

I acknowledge that this information is correct and hereby authorize a dental examination for my child including necessary radiographs, photographs and acceptable methods to accomplish these services. I authorize the release of any information to process insurance claims. I authorize payment of benefits directly to Dr. Deborah Ashcraft. I assume the responsibility for any and all charges incurred on behalf of my child for Dental/Medical treatment that is not covered by insurance. It is my responsibility to update the office with any address changes, insurance changes, or changes in my child's medical health condition.

Signature:_____**Relationship:**_____**Date** _____