



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

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