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**PATIENT INFORMATION AND HEALTH HISTORY FORM**

Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Age: \_\_\_\_\_ Sex:  Male  Female

**PARENT INFORMATION**

Parent/Legal Guardian: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
Parent/Legal Guardian: \_\_\_\_\_ Relation to patient: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_ Mobile #: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
Guardian's Email: \_\_\_\_\_  
Who has legal custody? \_\_\_\_\_ Dental Insurance  Yes  No  
Person responsible for payment of account \_\_\_\_\_ SSN#/Member ID#: \_\_\_\_\_  
Driver's License # \_\_\_\_\_

**WHOM MAY WE THANK FOR REFERRING YOU?**

Name: \_\_\_\_\_  
 www.ashevillepedo.com  Phone Book  Dental Office  Pediatrician  Other

**EMERGENCY CONTACT (other than parents)**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Mobile: \_\_\_\_\_

**HEALTH PROVIDER**

Child's Physician/Pediatrician: \_\_\_\_\_ Phone#: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_

**DENTAL HISTORY**

What is the reason for your child's dental visit? \_\_\_\_\_  
 Yes  No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) \_\_\_\_\_  
Name of previous dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Yes  No Has your child experienced any unfavorable reaction from previous dental care?  
Explain \_\_\_\_\_  
 Yes  No Does your child suck a finger, thumb, or pacifier (Please circle)? If so, when? \_\_\_\_\_  
 Yes  No Does your child go to bed with a bottle or sippy cup? If so, what is in it? \_\_\_\_\_  
 Yes  No Does your child snack frequently? What are their favorite snack foods? \_\_\_\_\_  
 Yes  No Has your child had local anesthetic? Were there any problems? \_\_\_\_\_  
 Yes  No Has your child been sedated for dental treatment? Were there any problems? \_\_\_\_\_  
 Yes  No Have your child's teeth ever been injured? Which teeth: \_\_\_\_\_  
Dental treatment for trauma: \_\_\_\_\_  
 Yes  No Has your child or anyone in your immediate family ever had a cavity? If so, who and when? \_\_\_\_\_  
 Yes  No Has your child or anyone in your immediate family ever had a cold sore or other mouth ulcer? Please describe: \_\_\_\_\_

Please check if your child is having problems with any of the following:

- Cavities  Toothache  Sensitive Teeth  Mouth Breathing
- Trauma  Gum Infections  Color of Teeth  Other
- Orthodontics  Jaw Sounds  Grinding of Teeth

Comments: \_\_\_\_\_



For office use only

CRA: L M H \_\_\_\_\_

### FLUORIDE HISTORY

- Yes  No Is your home water supply fluoridated or does your child have other access to fluoridated water?  
 Yes  No Does your child use a fluoride toothpaste?  
 Yes  No Do you give your child any other forms of fluoride? What? \_\_\_\_\_

### MEDICAL HISTORY

- Yes  No Is your child in good health? Date of last physical exam \_\_\_\_\_  
 Yes  No Has your child ever had a health problem? \_\_\_\_\_  
 Yes  No Is your child allergic to anything? \_\_\_\_\_  
 Yes  No Is your child currently taking any medications? Please give medication, dose, and reason: \_\_\_\_\_  
\_\_\_\_\_  
 Yes  No Are your child's immunizations current?  
 Yes  No Have you ever been told that your child needs to take *antibiotics before dental treatment*?  
 Yes  No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain:  
\_\_\_\_\_  
 Yes  No Were there any difficulties at birth? \_\_\_\_\_

Do you consider your child to be:  advanced  progressing normally or  slow in the learning process

#### Please check if you child has been treated for any of the following:

- |                                               |                                                    |                                                  |                                           |
|-----------------------------------------------|----------------------------------------------------|--------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Heart disease        | <input type="checkbox"/> Heart murmur              | <input type="checkbox"/> Bleeding/transfusions   | <input type="checkbox"/> Asthma/breathing |
| <input type="checkbox"/> Anemia               | <input type="checkbox"/> Blood dyscrasias          | <input type="checkbox"/> Tonsil/adenoid problems | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Liver/GI disease     | <input type="checkbox"/> Sickle cell disease/trait | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> AIDS             |
| <input type="checkbox"/> Kidney disease       | <input type="checkbox"/> Rheumatic fever           | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Mental delays    |
| <input type="checkbox"/> Speech/hearing       | <input type="checkbox"/> Seizures                  | <input type="checkbox"/> Cleft lip/palate        | <input type="checkbox"/> Physical delays  |
| <input type="checkbox"/> Eyesight             | <input type="checkbox"/> Congenital birth defects  | <input type="checkbox"/> Personality/social      | <input type="checkbox"/> Cancer/tumors    |
| <input type="checkbox"/> Recurrent headaches  | <input type="checkbox"/> Frequent Infections       | <input type="checkbox"/> Adverse drug reactions  | <input type="checkbox"/> Cerebral palsy   |
| <input type="checkbox"/> Significant injuries | <input type="checkbox"/> Endocrine/growth          | <input type="checkbox"/> Autism                  | <input type="checkbox"/> Arthritis        |
| <input type="checkbox"/> ADHD                 | <input type="checkbox"/> Spina bifida              | <input type="checkbox"/> Snoring                 | <input type="checkbox"/> Abuse            |

Other: \_\_\_\_\_  
If any boxes checked, please describe further: \_\_\_\_\_

### CONSENT FOR DENTAL TREATMENT

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. I do hereby request and authorize Dr. Jenny Jackson and her staff to perform any necessary dental services including but not limited to a comprehensive examination, cleanings, fluoride treatment, any necessary dental treatment for my child's teeth, X-rays as necessary to diagnose and/or treat my child's dental problem, and administration of anesthetics that are deemed advisable by Dr. Jackson, whether or not I am present when the treatment is rendered. The usual and most frequent risks or complications occurring from dental operative treatment include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Jackson will provide an environment that will help your child learn to cooperate during treatment including praise, explanations, and demonstrations of procedures and instruments, and using variable voice tones. I will be responsible for any charges incurred for my child for dental treatment.

For the purposes of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Asheville Pediatric Dentistry of any changes in my child's medical status.

**Legal Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

