



**Southern Village  
PEDIATRIC DENTISTRY**

Growing Healthy Smiles  
919-967-2773

410 Market Street, Suite 430  
Chapel Hill, NC 27516

**PATIENT INFORMATION AND HEALTH HISTORY FORM**

Child's Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Age: \_\_\_\_\_ Preferred Pronoun:  He/Him  She/Her  They/Them  
School Currently Attending: \_\_\_\_\_ Grade Level: \_\_\_\_\_

**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#: \_\_\_\_\_

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

Our Website  Building Sign  Postcard/Mailing  Pediatrician  Carolina Parent  Community Event  
 Dental Office  School/Daycare  Chapel Hill Weekly  Other  
Please Specify: \_\_\_\_\_

**EMERGENCY CONTACT**

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

**HEALTH PROVIDER**

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

**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?  
 Yes  No Does your child have pain with chewing, yawning, or wide opening?  
 Yes  No Does your child go to bed with a bottle or sippy cup?  
 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: \_\_\_\_\_

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

- |                                       |   |  |  |
|---------------------------------------|---|--|--|
| <input type="checkbox"/> Cavities     | <input type="checkbox"/> Toothache      | <input type="checkbox"/> Sensitive Teeth   | <input type="checkbox"/> Mouth Breathing |
| <input type="checkbox"/> Trauma       | <input type="checkbox"/> Gum Infections | <input type="checkbox"/> Color of Teeth    | <input type="checkbox"/> Other           |
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw Sounds     | <input type="checkbox"/> Grinding of Teeth |  |

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

### FLUORIDE HISTORY

What is your home water source:  City  Well

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 anyone in your immediate family travelled to: Liberia, Sierra Leone or Guinea in the last 21 days?  
If yes, please let us know when you arrived into the U.S.? Month \_\_\_\_\_ Day \_\_\_\_\_

Yes  No Is your child feeling feverish today?

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 in the learning process  
 progressing normally  
 slow in the learning process

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

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

\*\*Please note that if your child has an **active** herpes lip lesion on the day of your scheduled appointment, we will ask you to reschedule.

Other: \_\_\_\_\_

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

### CONSENT FOR DENTAL TREATMENT

As the parent and/or legal guardian of the patient, I do hereby request and authorize Dr. Annelise Hardin and her staff to examine, clean, and provide dental treatment on my child. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Hardin to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. 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. Hardin 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. 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 I will be responsible for any charges incurred for my child for dental treatment. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Southern Village Pediatric Dentistry of any changes in my child's medical status.*

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

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