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: __________ Sex: ☐ Male ☐ Female
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:
□ Cavities □ Toothache □ Sensitive Teeth □ Mouth Breathing
□ Trauma □ Gum Infections □ Color of Teeth □ Other
□ Orthodontics □ Jaw Sounds □ 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:

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

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:**____________________