André L. Lewis, D.D.S.

PEDIATRIC DENTISTRY

Pt# _____

G# _____

We welcome your child into our practice and we will do our best to make the dental experiences pleasant ones. If you or your child have any problems completing this form, we will be happy to assist you.

Date _____

PATIENT'S HISTORY

Child's full name _____ Nickname _____

Birthdate _____ Place _____

Age _____ Sex _____ School _____ Grade _____

Pets _____ Talents or Interests _____

Describe child's temperament _____

Name and ages of brothers and sisters _____

List any family members we have seen _____

Child's Physician _____

Address _____ Zip _____ Phone _____

GENERAL INFORMATION

Father's name _____ Mother's name _____

Home Address _____ City _____ Zip _____

Home Phone: _____ Cell Numbers Mother: _____ Father: _____

Email Address: _____

Marital Status: Married Widowed Single Divorced

Please list the best number(s) to text or call for your child's appointment confirmations:

Text _____ Call _____

Father's occupation _____ Social Security # _____

Work Address _____ Phone Number _____

Mother's occupation _____ Social Security # _____

Work Address _____ Phone Number _____

Do you have dental insurance? _____ If so, what company _____

Name of insured: _____ Date of birth _____

Family Dentist _____

Name of nearest relative not living with you _____

Address _____ Phone _____

Whom may we thank for referring you to our office? _____

A broken appointment is a loss to everyone. Please inform us one day in advance if you are unable to keep your appointment. We reserve the right to charge for appointments cancelled or broken without 24 hours advance notice.

–Continued On Reverse Side –

MEDICAL HISTORY

Has your child had any of the following:

Allergies	Yes ☐ No ☐	Fainting	Yes ☐ No ☐	Emotional Problems	Yes ☐ No ☐
Anemia	Yes ☐ No ☐	Hearing	Yes ☐ No ☐	Seizures	Yes ☐ No ☐
Asthma	Yes ☐ No ☐	Heart Trouble	Yes ☐ No ☐	Other	Yes ☐ No ☐
Bleeding	Yes ☐ No ☐	Hepatitis	Yes ☐ No ☐		
Blood Pressure	Yes ☐ No ☐	Malignancies	Yes ☐ No ☐	Weight _____	
Chronic Sinus	Yes ☐ No ☐	Mouth Injuries	Yes ☐ No ☐		
Diabetes	Yes ☐ No ☐	Rheumatic Fever	Yes ☐ No ☐	Height _____	

Please explain any "YES" answers _____

_____

_____

_____

Has your child had any surgery?_____List _____

Is your child mentally or physically handicapped? _____

Is your child taking any medicines?_____If so, what? _____

Condition of child's general health _____

Date of last physical exam_____Where? _____

DENTAL HISTORY

What is the reason for this visit?_____

Is this your child's first visit to the dentist?_____

Date of last dental care_____Where? _____

Has your child ever been exposed to unpleasant dental or medical experiences? _____

_____

Has your child ever had a reaction to dental anesthetic? _____

Is your child presently taking a fluoride supplement? _____

How often does your child brush? _____ Do you help?_____

Does your child have any mouth habits (thumb-sucking, lip-biting, etc.)? _____

Does your child eat a well balanced diet (fruits and vegetables, etc.)? _____

What are your child's snacking habits? _____

Has anyone in the family had an unusual dental problem? _____

Do you have any concerns you would like to discuss with the doctor? _____

_____

AUTHORITY TO TREAT

I hereby authorize Dr. Andre L. Lewis to treat the above mentioned patient using restorative and patient management techniques that are acceptable and proper. I understand that a treatment plan with associated fees will be discussed fully with the parent prior to the beginning of any treatment. I also understand that the treatment plan and fees could change depending upon the time elapsed since the initial examination. In addition, I authorize release of this information to the patient's medical doctor of record.

Signed _____ Date_____

Relationship to patient _____