Farmer Pediatric Dentistry, PSC

Andrew B. Farmer, DMD

68 Nautilus Drive~Hazard, KY~41701 Telephone: 606-436-KIDS (5437) Fax: 606-436-5438 Web: www.farmerpediatricdentistry.com

Demographic Information

Patient's Full Name: _____ Preferred name: _____ Today's Date: _____

Birthday: _____ Age: _____ Sex: _____ Ethnicity: _____

Patient's SSN: _____ School: _____ Grade: _____

*The person who brought the patient to the appointment today and who is completing this form is:

- ☐ Biological Mother
- ☐ Biological Father
- ☐ Legal Guardian
- ☐ Foster Parent
- ☐ Other _____

Biological Mother's Name: _____ Birthdate: _____ SSN: _____

Phone: _____ Mailing Adress: _____

Employer _____

Biological Father's Name: _____ Birthdate: _____ SSN: _____

Phone: _____ Mailing Adress: _____

Employer _____

Legal Guardian: _____ Birthdate: _____ SSN: _____

Phone: _____ Mailing Adress: _____

Employer _____

Who has legal custody of the patient? _____

Person to be contacted in case of emergency other than persons listed above:

Name _____ Relation: _____ Phone: _____

Do we see other children in your family? Yes No Names: _____

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

I have answered all questions to the best of my knowledge and understanding and take full responsibility for the information provided.

Signature: _____ Date: _____

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MEDICAL HISTORY

Patient's Full Name: _____ Preferred name: _____ Today's Date _____

Patient's Date of Birth: _____ Patient's Weight: _____ Patient's Physician: _____

Medication/Food Allergies	
Medication/Food	**Reaction**

Medication List	
Name	**Dose/ Frequency**

Surgery/Hospitalization History	
Type	**Date**

Are immunizations up to date? Yes No

Does your child have or has your child ever had any of the following:

☐Asthma	☐Brain Injury	☐Diabetes	☐Lactose Intolerance	☐Sleep Apnea/Snoring
☐Autism	☐Blood Transfusion	☐Emotional Disorder	☐Latex Allergy	☐Speech Disorder
☐Anxiety Disorder	☐Cancer	☐Endocrine Disorder	☐Learning Disorder	☐Spina Bifida
☐AIDS/HIV	☐Cerebral Palsy	☐Epilepsy/Seizures	☐Liver Disease	☐Syndrome
☐ADHD	☐Cleft Lip	☐Eye Problem	☐Lung Problem	☐Thyroid Disorder
☐Behavior Disorder	☐Cleft Palate	☐Heart Problem	☐Nervous Disorder	☐Tuberculosis
☐Birth Defects	☐Depression	☐Hepatitis	☐Premature Birth	☐Tumor
☐Blood Disorders	☐Developmental Disorder	☐Kidney Disease	☐Rheumatic Fever	

If your child has a condition not listed above, please explain: _____

DENTAL HISTORY

- Is today your child's first visit to the dentist? Yes No
- Purpose of this visit: _____
- Name of previous dentist: _____ Date of last visit: _____
- If your child has had any unfavorable dental experience, please explain _____

How often does child brush teeth? _____ Floss? _____ Does someone assist child? Yes No

If child has ever had an injury to face/teeth, please describe: _____

Are there any mouth/sucking habits (circle all that apply)? finger, thumb, pacifier, tongue thrust, grinding, mouth breather

Was your child breast fed or bottle fed? Breast Bottle At what age stopped? _____

Do you expect your child to cooperate for the exam? Yes No

Is there any information that you feel might be of value to us in treating your child? _____

I have answered all questions to the best of my knowledge and understanding and take full responsibility for the information provided.

Signature: _____ Date: _____

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Fluoride History

- Is your home water supply fluoridated? Yes No
- Does your child use a fluoridated toothpaste? Yes No
- Which water source is the child mostly drinking? City Well Bottled Other
- Does your child receive any other form of fluoride? Yes No What?

Diet Survey

Please estimate your child's daily exposure to the following items:

Soda:_____

Juice:_____

Milk:_____

Water:_____

Cookies/crackers/cereal:_____

Fruit snacks/fruit roll-ups:_____

Sticky candies (taffy, tootsie rolls, etc.):_____

Potato chips: _____

Natural fruit: _____

I have answered all questions to the best of my knowledge and understanding and take full responsibility for the information provided.

Signature: _____ Date: _____