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Pediatric Dentistry

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THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANKS FOR COMPLETING IN FULL.

Patient's Name _____ Nickname _____ Age _____

Sex _____ Race _____ Date of Birth _____ Place of Birth _____

Patient's Address _____ Home Phone _____
Street City State Zip

Name and Phone Numbers for Confirmation of Appointment _____

With whom does patient live _____

Father's Name _____ Date of Birth _____ Social Security # _____

His Address _____ Phone _____
Street City State Zip

Email _____ Cell Phone _____

Where Employed _____ Phone _____

Stepfather's Name _____ Date of Birth _____ Social Security # _____

His Address _____ Phone _____
Street City State Zip

Email _____ Cell Phone _____

Where Employed _____ Phone _____

Mother's Name _____ Date of Birth _____ Social Security # _____

Her Address _____ Phone _____
Street City State Zip

Email _____ Cell Phone _____

Where Employed _____ Phone _____

Stepmother's Name _____ Date of Birth _____ Social Security # _____

Her Address _____ Phone _____
Street City State Zip

Email _____ Cell Phone _____

Where Employed _____ Phone _____

Other children in family – names and ages _____ Have we seen them? _____

Dental Insurance? Yes _____ No _____ Primary Carrier _____ Secondary Carrier _____

Medicaid? Yes _____ No _____ Number _____ Other Funds _____

Child's Physician _____ Family Dentist _____

Whom may we thank for referring you to our office _____
(Doctor) or (Parent) or (Patient)

Address, if known _____
Street City State Zip

HEALTH HISTORY

Yes

No

Is your child in good health? _____

Does your child have regular medical examinations? _____

Is your child up to date with immunizations? _____

Is this your child's first dental visit? _____

Is your child a thumb/finger sucker? _____ Use a pacifier? _____

If your child was bottle fed, at what age was it discontinued? _____

Check any of the following that may pertain to your child:

- | | | | |
|---|--|---------------------------------------|---|
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Bleeding disorder | <input type="checkbox"/> Lung problem | <input type="checkbox"/> Mental disorder |
| <input type="checkbox"/> Heart condition | <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Brain injury | <input type="checkbox"/> Emotional disorder |
| <input type="checkbox"/> Speech disorder | <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Hearing disorder | <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Vision disorder | <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Nervous disorder | <input type="checkbox"/> Allergies | <input type="checkbox"/> Retardation | <input type="checkbox"/> Other |

Is your child presently taking any medications? _____
Name of Medication

Has your child experienced any unfavorable reaction to medicine? Yes _____ No _____
(Such as penicillin, aspirin, xylocaine)

Is your child presently undergoing medical treatment? Yes _____ No _____

Has your child ever been hospitalized since birth? Yes _____ No _____

If so, Date: _____ Reason _____

Has your child ever had an unfavorable experience in a dental office? Yes _____ No _____

Date of your child's last dental care _____

Does your child have a toothache? _____

Purpose of this appointment _____

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment.

Parent bringing patient to our office is responsible to us for payment of account. I agree to treatment and care deemed necessary by the office staff for the safety and well being of the child.

Signature of person responsible for payment of account

Signature of person completing form