Just 4 Kids Teeth

410 Parrish Place, Ste. 1000 Hendersonville, TN 37075 / 615-824-1700

Today's Date: ________________ PHONE NUMBER UPDATE: Cell: __________________ Home: _________________

Patient Name: ____ Patient DOB: ____________________________

Address: ____ City: __________________ State: ____ Zip: _________

Email Address: _______________________________________

WE DO NOT RE-VERIFY YOUR INSURANCE AT EVERY VISIT: DENTAL Insurance Name: _______________________

Subscriber Name: ______________________________ Subscriber Employer: _________________________________

Medical History

Subscriber DOB: ___________________ Subscriber SSN/ID#: ____

We apply Fluoride varnish on all children's teeth at every cleaning visit to prevent tooth decay.

Do you approve this today? Yes / No

*****Please note, your insurance may not cover Fluoride 2 times in a calendar year. The American Academy of Pediatric Dentistry recommends children receive at both cleaning visits.*****

☐ **Please review below. If nothing has changed from last visit please check box.**

Is your child presently under the care of a Pediatrician, Family Physician, Cardiologist, or Specialist for any medical reason? Yes / No If yes, please describe ____

1. Physician's Name: _____________________________________ Phone: _______________________________

Does your child have any drug allergies? Yes / No If yes, please describe: _________________________________

Is your child taking any medications at this time? Yes / No If yes, list: ____________________________________

Has your child ever been hospitalized or treated in an emergency room for trauma? Yes / No

If yes, when and for what reason: ____

Does your child have / had, any emotional, mental or nervous disorders? Yes / No

If yes, when and for what reason: ____

Have your child's tonsils and/or adenoids been removed? Yes / No

Please list any previous surgeries: ____

Please mark if your child has had any of the following:

ADD / ADHD		Cerebral Palsy		Other	
Cleft Palate		Chicken Pox		Measles / Mumps	
Malignancies/Leukemia		Diabetes		Neurological Disorders	
AIDS / HIV Positive		Down Syndrome		Physical Delays	
Anemia		Epilepsy / Seizures		Recurrent Headaches	
Asthma		Fainting		Rheumatic / Scarlet Fever	
Autism		Frequent Infections		Sensory Integration Disorder	
Behavioral Problems		Heart Murmur		Speech Problem	
Bone Disorder		Herpes / Cold Sores		Tobacco / Drug Use	
Blood Dyscrasias		Kidney Disease		Tuberculosis	
Cancer / Tumors		Liver Problems / Hepatitis		Congenital Heart Disease	

If marked yes, has this child had treatment for any of the above? Yes / No

SIGNATURE: ____ DATE: _______________________