

Edward M. Miller, D.D.S., M.S.
504J East Cornwallis Drive
Greensboro, North Carolina 27405
(336) 378-1421

Dr. Miller is a Pediatric Dentist.

The following information is necessary for adequate treatment and understanding of your child. We wish to thank you for completing it in full.

Date _____

Child's name _____ Sex _____

Nickname _____ Date of birth _____ Age _____ Grade _____

School _____

Child's interests (name and type of pet, sports, hobbies, favorite T.V. show, favorite toy, etc.) _____

Father's name _____ Home phone _____

Social Security number _____ Date of Birth _____

Mailing address _____ City _____ State _____ Zip _____

Father employed by _____ Phone _____

Business address _____

Present position _____ How long held? _____

Mother's name _____ Home phone _____

Social Security number _____ Date of Birth _____

Mailing address _____ City _____ State _____ Zip _____
(if different from father's)

Mother employed by _____ Phone _____

Business address _____

Present position _____ How long held? _____

In case of emergency, whom should be notified? _____ Phone _____

Who will pay this account? _____
(if other than parent)

Do you have insurance that may cover any part of our professional service? Yes _____ No _____

Other children in family _____
(names and ages)

Whom may we thank for referring your child? _____

Comments _____

Please complete both sides.

DENTAL HISTORY

..... Yes No
Do you want complete dental treatment for your child?

Do you and your spouse have regular dental examinations?

What is your main concern about your child's dental health? _____

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

If not, give date of last visit to a dentist, and service performed. _____

Has your child ever complained about a dental problem, or had any unhappy dental experiences?

Please explain _____

Is your child presently having a dental problem?

Please describe _____

Was your child breast fed?

Was your child bottle fed?

Age when your child began drinking from a cup _____

Does your child have any of the following habits?

thumbsucking or finger sucking

nail biting.....

mouth breathing.....

pacifier sucking

other _____

Does your child have any missing or lost teeth?

Has your child ever worn orthodontic appliances?.....

How often are your child's teeth brushed? _____

How often are your child's teeth flossed? _____

Is your child assisted in brushing?.....

Is your child assisted in flossing?

Do you have well water at home?

Do you give or have you given your child any form of fluoride?.....

Has your child ever received fluoride treatments?

Does your child have frequent "cold sores" or "fever blisters"?.....

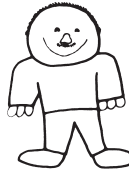
Do you consider your child to be (check one)

Advanced in learning process Progressing normally A slow learner

Has your child inherited any dental problem?

Please describe _____

Please complete both sides



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Child's Name _____

HEALTH HISTORY

Child's Physician _____

Physician's Address _____ Phone _____

Date of last physical examination _____ Results _____

	Yes	No
Does your child have regular physical examinations?.....	<input type="checkbox"/>	<input type="checkbox"/>
Is child under care of physician now?.....	<input type="checkbox"/>	<input type="checkbox"/>
For what? _____		
Is child receiving any medication or drugs now?	<input type="checkbox"/>	<input type="checkbox"/>
Name drug(s) _____		
Is there any excessive bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>
Has child ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>
Give date(s), hospital(s), and details _____		

Has child ever had surgery?	<input type="checkbox"/>	<input type="checkbox"/>
Give date(s), hospital(s), and details _____		
Is there any allergy or reaction to penicillin or other drugs?	<input type="checkbox"/>	<input type="checkbox"/>
Name drug(s) _____		
Are there other allergies: food-pollen-animals-dust-other?	<input type="checkbox"/>	<input type="checkbox"/>
Name substance(s) _____		
Has child ever had prolonged medical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Explain _____		
Does child have good physical coordination?	<input type="checkbox"/>	<input type="checkbox"/>
Explain _____		
Are there any emotional, mental, or nervous disorders?	<input type="checkbox"/>	<input type="checkbox"/>
Describe _____		
Does your child have any problems at school?	<input type="checkbox"/>	<input type="checkbox"/>
Explain _____		

Check if child has any history of or difficulty with any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Drug Habits | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fainting | <input type="checkbox"/> Pregnancy |
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Hearing | <input type="checkbox"/> Reflux |
| <input type="checkbox"/> Bleeding excessively | <input type="checkbox"/> Heart | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Hepatitis (Yellow Jaundice) | <input type="checkbox"/> Sinus |
| <input type="checkbox"/> Blood pressure | <input type="checkbox"/> Hereditary disorders | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Cerebral palsy | <input type="checkbox"/> Kidney | <input type="checkbox"/> Tonsils |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Liver | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cleft Palate | <input type="checkbox"/> Cancer | <input type="checkbox"/> Venereal Disease (VD) |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Mastoid | <input type="checkbox"/> Other Physical or |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Mental Problems |

Has any immediate family had any of the above? _____

Please describe _____

Doctor's remarks _____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or special needs of which I should be aware. _____

May we request release of your child's medical records for our reference? Yes No

This information was discussed with and given by _____

Relation to child _____

Child's weight:	Height	as of (insert date)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please complete both sides.