Children's Smiles Start Here
www.CaseyDentalDDS.com

Patient Information

Child's Full Name _____ Name Called By _____
Age _____ Birthday _____/____/_____ SEX: M/F _____ Place of Birth _____
Child's Home Address _____
City _____ State _____ Zip Code _____ Home Phone ( ) _____
Child's Favorite Hobbies/Interests _____

Parent/Guardian Information

Parent/Guardian Name _____Relationship to patient _____
Address if Different From Home Address of Patient _____
Social Security # _____ Date of Birth _____
Email Address _____ Employer _____
Marital Status ___Married ___Divorced ___Widowed ___Separated ___Partner ___ Other ___
Home Phone _____ Cell Phone _____ Work Phone _____
How would you like to be contacted Phone ___ Email ___ Text ___

Parent/Guardian Name _____Relationship to patient _____
Address if Different From Home Address of Patient _____
Social Security # _____ Date of Birth _____
Email Address _____ Employer _____
Marital Status ___Married ___Divorced ___Widowed ___Separated ___Partner ___ Other ___
Home Phone _____ Cell Phone _____ Work Phone _____
How would you like to be contacted Phone ___ Email ___ Text ___
How did you find out about our office? _____
Do you carry Dental insurance? Yes ___ No ___ Name of dental insurance company _____

Medical History

Please check the following health problems that your child currently has or has previously experienced.

___Allergies (Latex, Penicillin, Eggs, Nuts, Food, Dust, Drug, Unknown). If yes, please list _____
___ Rheumatic Fever/Rheumatic Heart Disease
___ Congenital Heart Disease for Heart Murmur
If yes, is Premed needed? _____
___Glandular or Hormonal Problems
___Diabetes/Blood Sugar Problems
___Arthritis or Rheumatism (painful, swollen joints)
___Convulsions, Seizures, Fainting or Epilepsy
___High/Low Blood Pressure
___ Any Current/Recent Injuries
___ Blood Transfusion
___Any Prolonged Bleeding/Bruises Easily
___Kidney or Bladder Problems
___Tuberculosis or Pneumonia
___ Liver Problems, jaundice or Hepatitis
___Accidents or Severe Infections
___Psychological or Emotional Problems
___Any Pending/Recent Surgeries
___Speech, Learning or Hearing Disorders

Children's Smiles Start Here
www.CaseyDentalDDS.com

Medical History (Continued)

___ Anemia or Blood Disorders
___Asthma or Hay Fever (If yes please indicate and list current medications)_____
_____
Are your child's immunizations current? _____
Does your child have any special needs or circumstances? (i.e.) Autism Cerebral Palsy, Downs Syndrome _____
_____

Dental History

Date of Last Dental Visit _____ By Dr. _____
Do you have any current records (including x-rays) from another practice? ___Yes ___ No
Has your child complained about any dental problems? _____
Any injuries or surgeries to mouth, teeth, head? ___Yes ___No If yes please describe _____
_____
Does your child still take the bottle or Sippy cup? _____
What does your child usually drink? _____
Does your child brush daily? ___Yes ___No If yes, how often? _____
Do you assist your child with brushing? ___Yes ___No If yes, how often? _____
Is Dental Floss used? ___Yes ___No

Please check if your child has any of the following mouth habits

___Thumb Sucking ___Mouth Breathing ___Pacifier ___Nail Biting ___Finger Sucking ___Grinding
___Other _____

How does your child receive Fluoride?

___Water Supply ___Dentist ___Toothpaste ___Vitamins ___Tablets ___None
___Other, please explain _____
Child's Attitude towards Dentistry _____
Reason for Today's Visit/Chief Concerns _____
_____

I hereby certify that all of the above information is correct and true. Because the above-named child is a minor, it is necessary that a signed permission is obtained from a parent or guardian before any and/or all necessary dental treatment can be commenced. I agree to diagnostic procedures and dental treatment as found by Dr. James T. Casey II, DDS or doctors working with Dr. James T. Casey II, DDS for the dental services for my child. I understand that I am responsible for all charges whether or not covered by insurance.

Relationship to Patient _____

Signed _____Date _____

Casey Dental 1431 E. Arlington Blvd Greenville, NC 27858 Phone (252) 751-0556 Fax (252) 751-0564