**ANGELA B. BATESON, DDS**
GENERAL DENTISTRY
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## CHILD'S INFORMATION

Your child _____ Date _____
LAST FIRST MI (PREFERRED NAME)

Birth date _____ Gender: ❑Male ❑Female Child's Social Security # _____

Phone (home) _____ School _____ Grade _____

Preferred method to notify you of your child's appointments ❑ Home ❑ Work ❑ Cell ❑ E-Mail ❑ Text Message

Preferred appointment times ❑ Morning ❑ Afternoon ❑ Evening ❑ Any Time Preferred appt. days ❑M ❑ T ❑W ❑Th ❑F

Child's home address _____
STREET APARTMENT #

_____
CITY STATE ZIP CODE

Emergency contact: _____
NAME / RELATIONSHIP PHONE

## MEDICAL & DENTAL HEALTH INFORMATION

Date of last dental visit _____ Reason for that visit: _____

Has your child ever had any of the following? Please check all that apply:

MEDICAL HISTORY
- ❑ Aids / HIV
- ❑ Allergies
- ❑ Anemia
- ❑ Arthritis
- ❑ Artificial joints
- ❑ Asthma
- ❑ Blood disease
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Congenital heart defect
- ❑ Diabetes
- ❑ Epilepsy

Medical History continued
- ❑ Excessive bleeding
- ❑ Eye disorders
- ❑ Handicaps/disabilities
- ❑ Hay fever
- ❑ Head injuries
- ❑ Heart disease
- ❑ Heart murmur / mvp
- ❑ Hepatitis / jaundice
- ❑ Immune disorders
- ❑ Kidney disease
- ❑ Latex allergy
- ❑ Liver disorders

DRUG ALLERGIES
- ❑ Codeine allergy
- ❑ Penicillin allergy
- ❑ Other drug allergies (please list)

_____
_____
_____
_____

DENTAL HISTORY
- ❑ Bad breath
- ❑ Bite / chew nails
- ❑ Biteguard therapy
- ❑ Bleeding gums
- ❑ Bleaching treatment
- ❑ Blisters / sores on lips
- ❑ Clench / grind teeth
- ❑ Mouth breathing
- ❑ Severe gag reflex
- ❑ Suck / bite lip
- ❑ Suck thumb / finger
- ❑ Wisdom teeth removed

- Has your child ever had any complications following dental treatment? ❑ Yes ❑ No
  If yes, please explain _____
- Has your child been admitted to a hospital or needed emergency care during the past two years? ❑ Yes ❑ No
  If yes, please explain _____
- Is your child under the care of a physician? ❑ Yes ❑ No
  If yes, please explain _____
- Name of physician _____ Phone _____
- Prescribed medications: _____
- Has your child had orthodontic treatment? ❑ Yes ❑ No **If so, when?** _____