Welcome

Britt D. Vinson D.D.S., M.S.D.

Date: ____________________

Tell US ABOUT YOUR CHILD

Name: ____
Last First Middle

Likes to be called ____________________________________

Male ☐ Female ☐

Date of Birth: ___________________________ Age: _______

Address:____

____
City State Zip

Home Telephone: (______) __________ - ________________

School:________________________________ Grade: ________

Hobbies/ Interests: _____________________________________

Siblings and ages: ______________________________________

Family Dentist: ____

Parents' Marital Status

___Single ___ Married ___ Divorced ___ Widowed ___ Separated

Who will be responsible for the bill? __ Mother __ Father __ Both

If both, will it be equal responsibility? ____Yes ____No

If No, please explain ___________________________________

List any family members that have been treated by this office:

____

____

Referred By:____

Mother's Information

Name: ____
Last First

Address: ____
Street Apt/ Condo

____
City State Zip

Home Telephone: (____) ___________ - ______________

SSN: ____

Employer: ____

Occupation: _______________________________________

Work Telephone: (_____) ______________ - __________ext.___

Cell phone: (_______) _______________ - ________________

Does Mother have legal custody of this child? ____Yes ___No

Email Address: _____________________________________

Father's Information

Name: ____
Last First

Address: ____
Street Apt/Condo

____
City State Zip

Home Telephone: (______) ___________- ________________

SSN: ____

Employer: ____

Occupation: ____

Work Telephone (____) _____________ - _________________

Cell Phone (_____) ___________ - _______________________

Does Father have legal custody of this child? ____Yes ___No

Email Address:____

(Over)

Medical History

Physician's Name: ____

Is your child taking any medications (include over-the counter) ________ yes __________ no

Date of last visit____ Please list each drug: _____________________________

Current health is: ______ Good _____ Fair _____Poor

Does your child have a history of any of the following? (Please circle)

Abnormal Bleeding	Blood disorders	Epilepsy/Seizures	Mitral Valve Problems	Sinus Problems
Anemia	Blood Transfusions	Heart Disorders	Psychiatric Problems	Surgery
Acquired Immune Disorder	Cancer	Hospitalization	Radiation Treatment	Tuberculosis
Arthritis	Diabetes	Kidney Disorders	Rheumatic Fever	Ulcers/Colitis
Artificial Joints or valves	Difficulty Breathing	Lung Disorders	Scarlet Fever	Vision/Hearing
Asthma	Drug/ Alcohol Abuse	Migraines	Seasonal Allergies	

Other Medial problems: ____

Please explain any circled responses:____

____

Have adenoid and/ or tonsils been removed? _____ yes _____No If so, when? ____________________________________
In order to gauge growth, has puberty begun? _____ yes _____No Girls: Has menstruation begun? ____yes _____ No

Is your child allergic to any of the following? (Please Circle)

Anesthetics Aspirin Amoxicillin Codeine Cyclosporins Erythromycin Latex Metal

Penicillin Sulfa Drugs Tetracycline Other

Please list any other drugs or material your child may be allergic to:_______________________________________

Dental History

Dentist Name: ________________________ Date of last visit: ________________

(Circle all that apply)

Complication following dental treatment Toothaches or cavities at present Uses any type of fluoride products

Clicking /popping jaw pain Inherited any family or dental problems Grind/clench teeth day or night

Ever injured teeth Injured face or jaw Sucked fingers or thumb

Needs to be pre-medicated before dental treatment Tonsils or adenoids removed

Please explain any circled item(s) from above: ____

Realizing that successful treatment greatly depends upon the patient's cooperation in following instructions, keeping appointments and maintaining oral hygiene. Are there any restrictions, handicaps, or problems that might be encountered during treatment?
Yes _____ No_____ if yes, please expain:____

PERSON COMPLETING THIS FORM:

Signature: _______________________________________Relationship To Patient: _______________________________