

ASHBY PARK PEDIATRIC DENTISTRY

Jennifer G. Fogle, DMD

Sairah Awan, DMD

Dentistry for Infants, Children and Teens

100 Regent Park Court
Greenville, SC 29607
(864) 234-3424

The following information and history are necessary for the adequate treatment of your child. **Thank you for completing all information in full.**

SOCIAL HISTORY

Patient's Full Name _____ Preferred _____ Age _____ Sex _____

Race _____ DOB _____ Place of Birth _____ School _____

Patient's SSC# _____ - _____ - _____ Name & Type of child's Pet _____

Favorite Interest/hobby _____ Does your child fear Dentistry? _____

How do you expect your child to react to his/her visit today? Excellent Good Fair Poor Not Sure

The Parent or guardian that brings the child is responsible for the account.

Child lives with: Both parents Mother Stepmother Stepfather Grandparent Other _____

Patient's Address _____ City/State _____ Zip _____

Father's Full Name _____ DOB _____ Social Security # _____

His Address _____ City/State _____ Zip _____

Father's Home Phone _____ Cell Phone _____ Work Phone _____

Where Employed _____ Address _____

Mother's Full Name _____ DOB _____ Social Security# _____

Her Address _____ City/State _____ Zip _____

Mother's Home Phone _____ Cell Phone _____ Work Phone _____

Where Employed _____ Address _____

Other children in the family? Names and ages _____

Whom may we thank for referring you to our office? _____

Reason for bringing child to dentist _____

INSURANCE INFORMATION:

Child is insured by: Mom Dad Self (MEDICAID)# _____ Other(explain) _____

Insured Person's Full Name _____ DOB _____ Insured's SSC# _____

Insurance Company Name/address: _____ City/State/Zip _____

Insurance ID # _____ Group # _____ Ins. Co Phone number _____

EMERGENCY INFORMATION:

Name _____ Phone# _____ Relationship to patient: _____

Medical History:

Childs Physician _____ Address _____ Phone _____

Condition of Childs General Health _____ Year of last physical _____

Yes No Were there any problems during pregnancy or birth of your child? _____

Yes No Are your child's immunizations up to date? If no, explain _____

Yes No Is your child allergic to any medicines or foods? If yes, what? _____

Yes No Is your child taking any medicines now? If yes, what? _____

Yes No Have you ever been told by a physician that your child requires antibiotics prior to dental treatment? _____

Yes No Has your child ever been hospitalized or had an operation? If yes, explain _____

Yes No Has your child received medical treatment within the last 6 months? If yes, explain _____

Yes No Does your child have any physical or mental disabilities? If yes, explain _____

Yes No Does your child have any hearing, sight, speech, or learning problems? If yes, explain _____

Please check any that pertain to your child (explain if applicable)

Heart/Cardiovascular Condition Cerebral Palsy Hepatitis Diabetes

Mental/Emotional Disorder Rheumatic Fever Asthma Tuberculosis

Liver/Kidney Problem Bleeding Disorder Allergies Transfusion

Nervous System Problem Sickle Cell Anemia Epilepsy HIV/AIDS

DENTAL HISTORY

Yes No Is this your child's first dental visit? If no, name of previous Dentist _____

Yes No Are there any hereditary dental problems in the family (missing, extra teeth, etc.)? _____

Yes No Has your child or any family member experienced any unfavorable reaction from previous dental treatment? _____

Yes No Has your child ever received injuries to the head, mouth, jaws or teeth? Describe _____

Yes No Does your child have a thumb, finger or pacifier habit? _____

Yes No Does your child take fluoride supplements? _____

Private Well or public/city water? Yes No Was child breast or bottle fed? _____ To what age? _____

I agree to diagnostic procedures and dental treatments found necessary and desirable by Jennifer G. Fogle and/or Sairah Awan for the patient named above. I do also authorize and request the administration of such anesthesia and/or sedatives as may be deemed advisable by the above named doctor. I am aware that I will be informed of all services before any treatment is rendered to my child. I will accept responsibility for this account should named responsible party fail or insurance benefit be denied.

DATE: _____ SIGNATURE: _____