Charles R. Greenleaf, D.M.D.
841 N. Dean Road
Auburn, AL 36830
334-826-6651

www.auburnpediatricdentistry.com
info@auburnpediatricdentistry.com

Patient Information

Child's Name ____

Preferred Name ______________________ ❑ M ❑ F Child's Birthdate _____ / _____ / _______

PatientAddress:____

City:__________________________________ State:_________ Zip:______________________

Email Address:____

(We confirm appointments by text messages and e-mail, in addition to postcards)

Mother's Name

____

Mother's Address ❑ Check if same as child's

____

City:________________State:______Zip:________

Birthdate ____ / ____ / ____ Employer ________________

Cell # (________) ________-___________

Home # (________) ________-___________

Father's Name

____

Father's Address ❑ Check if same as child's

____

City:________________State:______Zip:________

Birthdate ____ / ____ / ____ Employer ________________

Cell # (________) ________-___________

Home # (________) ________-___________

Account Information

Person ultimately responsible for this account:

Name ______________________________________Relation to Child _________________________

Billing Address____

Cell # (________) ________-____________ Home # (_________) _________-____________

Policy Holder Information

Does the patient currently have **Dental Insurance**?

YES NO

Employer:______________________________

Card Holder's Name:______________________

SSN of Card Holder:________-______-___________

Card Holder's Date of Birth:____________________

Insurance Company:_________________________

Group/Contract Number:______________________

Does the patient currently have **Secondary Dental Coverage**?

YES NO

Employer:______________________________

Card Holder's Name:______________________

SSN of Card Holder:________-______-___________

Card Holder's Date of Birth:____________________

Insurance Company:_________________________

Group/Contract Number:______________________

Parent/Guardian Signature:________________________________ **Date:** ______________________

Medical History

Child's Name ____

Preferred Name _____________________ ❑ **M** ❑ **F** **Child's Birthdate** _____ / _____ / _______

Does the patient have any of the following?

ADD/ADHD	YES	NO	Cleft Lip	YES	NO	Kidney Disorder	YES	NO
Aids/HIV Positive	YES	NO	Cystic Fibrosis	YES	NO	Liver Disorder	YES	NO
Anemia	YES	NO	Diabetes	YES	NO	Lung Disorder	YES	NO
Asthma	YES	NO	Down's Syndrome	YES	NO	Mental Disorder	YES	NO
Aspergers Syndrome	YES	NO	Endocrine	YES	NO	Muscle Disorder	YES	NO
Autism	YES	NO	Gastric Reflux	YES	NO	Rheumatic Fever	YES	NO
Bleeding Disorder	YES	NO	Heart Defects	YES	NO	Seizures/Epilepsy	YES	NO
Bone Disorder	YES	NO	Heart Murmur	YES	NO	Sickle Cell Anemia	YES	NO
Cancer/Tumors	YES	NO	Hemophilia	YES	NO	Sleep Apnea	YES	NO
Cerebral Palsy	YES	NO	Hepatitis	YES	NO	Tuberculosis	YES	NO

Does the child have any allergies? **YES** **NO**
If YES, Name:____
____

Latex Allergies? **YES** **NO**
Milk Allergies? **YES** **NO**
Amoxicillin Allergies? **YES** **NO**

If YES on any, please elaborate:
____
____

Is the child currently being treated by a physician for any medical problems? **YES** **NO**
____

Is the child taking any medications? **YES** **NO**
If YES, Name:___________________________ Dose:____________ Reason:_____________________
Name:___________________________ Dose:____________ Reason:_____________________
Name:___________________________ Dose:____________ Reason:_____________________

Child's Dental Information

Has your child ever been to the dentist before? **YES** **NO**
If YES: Name of Office and Location**:** ____
Date of Last Cleaning: ____

Is your child currently seeing or have they previously seen an orthodontist? If Yes, When and Who?
____

How did you hear about us? Please circle one: Newspaper / Phone Book / Internet / We Visited your child's school or day care / Friend / Referring Doctor ______________________________Other______________________________

Is your child in pain? ❑ N ❑ Y For how long? _______________________________

Has the child been hospitalized, had any surgeries or been to the ER for any **tooth/mouth** related problems? **YES** **NO**
If YES, please elaborate: ____

How often does your child Brush? ______________ How often does your child Floss? _____________

Does child do any of the following? ❑ Thumb Sucking ❑ Tongue Thrusting ❑ Heavy Snoring ❑ Mouth Breathing
❑ Lip Sucking/Biting ❑ Tooth Grinding/Clenching ❑ Nail Biting ❑ Nursing

Parent/Guardian Signature:____ **Date:** _________________________