Jason B. Cellars, D.D.S.

Thank you for choosing our office for your dental treatment. In order that we may be more effective in meeting your child's needs, please complete this entire form in full.

Patient's name_____Nick name_____Age_____

Date of Birth_____Social Security Number_____

Residence Address_____City_____Zip_____

Father's name_____Residence Phone_____

Residence Address_____City_____Zip_____

Mailing Address_____City_____Zip_____

Date of Birth_____Social Security Number_____

Driver's License Number_____

Employed by_____Occupation_____

If self employed, name of business_____

Business Address_____City_____Zip_____Phone_____

Insurance company_____Group Number_____

Mother's name_____Residence Phone_____

Residence Address_____City_____Zip_____

Mailing Address_____City_____Zip_____

Date of Birth_____Social Security Number_____

Driver's License Number_____

Employed by_____Occupation_____

If self employed, name of business_____

Business Address_____City_____Zip_____Phone_____

Insurance company_____Group Number_____

In case of emergency, whom may we notify,_____Phone_____

Relation_____Address_____

Name of Pediatrician_____City_____Phone_____

Former Dentist (if any)_____City_____Phone_____

Purpose of appointment_____

Is this office visit for emergency dental care?_____

Please complete the other side

Medical History

1. Is you child allergic to Latex?.....yes no
2. Is your child under medical treatment now?.....yes no
   If so, what is the condition being treated?_____
3. Has your child ever had an serious illness or operation?.....yes no
   If so, what was the illness or operation?_____
4. Has your child ever been hospitalized?.....yes no
   If so, what was the problem?_____
5. Is your child taking any drugs or medications?.....yes no
   If so, what?_____What dosage?_____
6. Is your child allergic or sensitive to any drugs or medications?.....yes no
   If so, what?_____

7. Does your child have or have they had any of the following? (Please check known conditions)

___High Blood Pressure	___Liver Disease	___Tumors/Growths
___Heart Disease	___Asthma	___Sinus Trouble
___Rheumatic Fever	___Epilepsy/Convulsions	___Nervous Disorders
___Diabetes	___AIDS or HIV infection	___Dry Mouth
___Hepatitis/Jaundice	___Kidney Disease	___Difficulty with Swallowing
___Mitro Valve Prolapse (MVP)	___Tuberculosis	___Kidney Disease
___Cancer	___Herpes	___Excessive Bleeding
___Heart Murmur	___Allergies/Hay Fever	___Other_____

8. Does you child have any disease, condition or health problem not listed that we should know about? yes no
   If so, what?_____

Dental History

1. Is this your child's first visit to a dentist?.....yes no
2. Has your child ever had local anesthetic (lidocaine, novocaine, etc)?.....yes no
3. Has your child ever had any unfavorable reaction from a local anesthetic?.....yes no
4. Has your child ever had any serious trouble associated with any previous dental treatment?.....yes no
   If so, explain._____
5. How long since your child's last dental treatment?_____
6. How long since your child's last dental x-rays?_____
7. Are you satisfied with the appearance of your child's teeth?.....yes no
   If no, what would you like to be changed?_____
8. Does your child have an oral habit (thumb sucking, nail biting, etc.)?.....yes no
   If so, what is it?_____

Consent

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever have changes in their health, or if their medicines change, I will inform the doctor. I authorize the doctor to take radiographs, study models or any other diagnostics aids deemed appropriate in order to make a thorough diagnosis. I also authorize the doctor to perform any and all forms of treatment, medication and therapy, that may be indicated after proper explanation, alternatives and consequences have been given to me.

Signature of Parent or Guardian_____**Date**_____