



DEBORAH A. ASHCRAFT, DMD, PC
PEDIATRIC AND ADOLESCENT DENTISTRY

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Child's Biographical, Medical and Dental History (Please print clearly and fill out completely!)

Child's full name: (Last) _____ (First) _____ (Middle) _____
 Name child goes by: _____ Sex: M / F Race: _____ Birthdate: _____ Age: _____ Grade: _____ School: _____
 Address: (Street) _____ (City) _____ (Zip) _____ Home Phone: () _____
 Names and ages of other children in family: _____
 Do both parents live together? Yes No If not, with whom does the child live? _____
 Person financially responsible for account: _____
 Address if different from child's: _____ Home Phone: () _____
 Father's Name: _____ DOB: _____ SSN: _____
Drivers Lic./State: _____ Email Address: _____
 Occupation/Employer: _____ Work Phone: () _____
 Dental Insurance? Yes No Plan Name and Number: _____
 Mother's Name: _____ DOB: _____ SSN: _____
Drivers Lic./State: _____ Email Address: _____
 Occupation/Employer: _____ Work Phone: () _____
 Dental Insurance? Yes No Plan Name and Number: _____ Parent's SSN: _____
 If you do not have a phone, list a phone number/contact person, so you can be reached: () _____
 Whom may we thank for referring you? _____

Conditions: ✓ any which your child presently has or previously had; ✗ out any your child does not have & initial all!

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS _____ | <input type="checkbox"/> Cerebral palsy _____ | <input type="checkbox"/> High blood pressure _____ | <input type="checkbox"/> Muscle disorder _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Convulsions _____ | <input type="checkbox"/> HIV-positive _____ | <input type="checkbox"/> Nose/throat disorder _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Hormone disorder _____ | <input type="checkbox"/> Prolonged illness _____ |
| <input type="checkbox"/> Bleeding tendency _____ | <input type="checkbox"/> Ear disorders _____ | <input type="checkbox"/> Hyperactivity _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Blood disease _____ | <input type="checkbox"/> Epilepsy _____ | <input type="checkbox"/> Jaundice _____ | <input type="checkbox"/> Skin disorder _____ |
| <input type="checkbox"/> Blood transfusion _____ | <input type="checkbox"/> Eye disorders _____ | <input type="checkbox"/> Kidney disease _____ | <input type="checkbox"/> Speech problem _____ |
| <input type="checkbox"/> Bone disorder _____ | <input type="checkbox"/> Fainting _____ | <input type="checkbox"/> Liver disease _____ | <input type="checkbox"/> Stomach problem _____ |
| <input type="checkbox"/> Brain disorder _____ | <input type="checkbox"/> Heart condition _____ | <input type="checkbox"/> Lung disease _____ | <input type="checkbox"/> Tubes in Ear _____ |
| <input type="checkbox"/> Cancer or tumors _____ | <input type="checkbox"/> Hemophilia _____ | <input type="checkbox"/> Mental retardation _____ | <input type="checkbox"/> Other _____ |

Child's Physician: (Name): _____ (Phone): (_____) _____
 (Address): _____

No Yes Does your child have any other medical condition? _____
 No Yes **Is your child taking any medicine?** (Please list) _____
 No Yes **Is your child allergic to any medicine or food?** (Please list) _____
 No Yes **Has your child ever been hospitalized?** _____
 No Yes Is this your child's first visit to the dentist? **Date of last dental visit** _____
 No Yes **Were there any problems with previous dental treatment?** _____
 No Yes Is your child using fluoride tablets, drops or rinses?
 No Yes Has your child had a toothache recently?
 No Yes Does your child suck a thumb, finger or have any other oral habit? _____
 No Yes Has your child ever injured his/her teeth or jaws?
 No Yes Does your child have a dental condition about which you are especially concerned? _____

How often are your child's teeth brushed? _____ By whom? _____
What is the source of your child's drinking water? Public water Well water

I acknowledge that this information is correct and hereby authorize a dental examination for my child including necessary radiographs, photographs and acceptable methods to accomplish these services. I authorize the release of any information to process insurance claims. I authorize payment of benefits directly to Dr. Deborah Ashcraft. I assume the responsibility for any and all charges incurred on behalf of my child for Dental/Medical treatment. It is my responsibility to update the office with any insurance changes, or changes in my child's medical health condition.

Signature: _____ **Relationship:** _____ **Date** _____