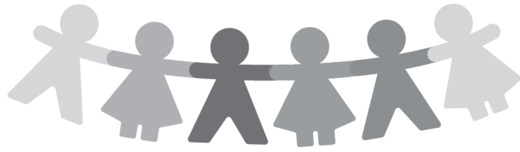

E. LaRee Johnson, DDS, MS, FAAPD -- Pediatric Dentist
Diplomate of the American Board of Pediatric Dentistry
Clark L. Morris, DDS -- Pediatric Dentist
Diplomate of the American Board of Pediatric Dentistry
M. Gentry Byrd, DDS, MPH -- Pediatric Dentist
Board Eligible, American Board of Pediatric Dentistry

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Raleigh, NC 27614-8898

510 Glenwood Ave, Suite 110
Raleigh, NC 27603

(919) 570-0180 fax (919) 570-0280

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NEW PATIENT INFORMATION

By completing this form thoroughly, you are assisting us to providing the most friendly, safe and efficient care for your child. A legal guardian for the child must complete this form.

Person completing form ______________ Relation to child ______________ Date ______________

Child Information

Child's name (First)______________ (M.I.)______________ (Last)______________
Nickname (that we can use) ______________ Child's date of birth ______________ Male / Female
Home address ______________ Home phone number ______________
City ______________ State______________ Zip Code______________
If your child attends school, where ______________ Grade ______________
Child's physician or pediatrician ______________ ***Phone number*** ______________
Siblings? If yes, please list name and age ______________
Sometimes we make conversation with children by talking about upcoming holidays, cartoon characters, tooth fairy, etc. Is this okay with you? ☐ Yes ☐ No ______________
Is there a favorite something we can talk to your child about? ______________
Comments ______________

Parent Information

Parent/Caregiver #1 Name (First)______________ (M.I.) ______________ (Last) ______________
Date of birth ______________ Social security number ______________ Mobile number ______________
Occupation ______________ Employer ______________ Work phone number ______________
Parent/Caregiver #2 Name (First)______________ (M.I.) ______________ (Last) ______________
Date of birth ______________ Social security number ______________ Mobile number ______________
Occupation ______________ Employer ______________ Work phone number ______________
Phone number to call to confirm appointments ______________
Email address ______________ I authorize patient photos to be sent to me by email at this address.
How did you hear about us? ______________ Family dentist name ______________

Financial Information

Person responsible for child's account ______________ Relation to child ______________
Do you have dental insurance? Yes / No
Insurance company name ______________ Phone number ______________
I hereby authorize my insurance company to send payments directly to Johnson, Morris, & Byrd PLLC and understand that I am responsible for all remaining balances.

______________ ______________
Signature Date

First Visit Expectations

Reason for visit ______________
Is this your child's first dental visit? ☐ Yes ☐ No If no, when was last visit? ______________
Has your child had dental x-rays in the past six months? ☐ Yes ☐ No
Who was your child's last dentist? ______________
What is your main concern about your child's dental health? ______________
Has your child ever complained about a dental problem, or had any unhappy dental experiences? ☐ Yes ☐ No
If yes, please explain. ______________
Is your child presently having any dental problems? ☐ Yes ☐ No
If yes, please explain. ______________
Do you have any other comments regarding your first visit here? ______________
____

Medical History

Please be specific about your child's health information. Circle the answer that applies and write details as needed:

Please list any medication (including dosage and frequency) your child takes: ______________________

____

Please list any drugs that have caused adverse reactions in your child: ______________________

Yes No ***Allergies to food or drugs***
Yes No Seasonal allergies
Yes No Anemia
Yes No Asthma or Reactive airway disease
Yes No Bleeding disorder
Yes No Cerebral Palsy
Yes No Diabetes
Yes No Epilepsy or Seizure disorder
Yes No Frequent infections
Yes No Hearing disorder
Yes No Behavioral or learning problems
Yes No Endocrine problems
Yes No Cancer
Yes No Allergy to wool or lanolin
Yes No ***Heart problems (including heart murmur)***
Yes No Headaches
Yes No Kidney, GI or liver disease
Yes No Lung or breathing problems
Yes No Mental disorder
Yes No Rheumatic fever
Yes No Autism
Yes No Down syndrome
Yes No Tonsil or adenoid problems
Yes No Snoring
Yes No Congenital birth defects
Yes No Mental or physical delays
Yes No Problems with sight
Yes No Diseases of blood
Yes No Blood transfusion
Yes No ***Immunizations current***
Yes No Reaction to balloons, pacifiers or any rubber goods (latex allergy). If yes, please explain ______________________

____

Yes No Any other medical issues. If yes, please describe ______________________
Yes No Hospitalized. If yes, please describe ______________________
Yes No Any family members have any of the problems listed above. If yes, please describe (and include the relationship to the child) ______________________
Yes No I would consider my child to be in good health. If no, please explain ______________________

____

Yes No I expect my child to cooperate for dental treatment. ______________________

Is there any other information that you feel might be of value to us in treating your child? ______________________

____

Dental History

Please be specific about your child's health information. Circle the answer that applies and write details as needed:

Yes No TMJ/TMD (clicking or "popping" in the jaw)
Yes No Finger habit/when stopped ______________
Yes No Thumb habit/when stopped ______________
Yes No Other habit ______________
Yes No Nail biting
Yes No Mouth breathing
Yes No Has your child ever worn an orthodontic appliance?
Yes No Has your child received any fluoride treatments?
Yes No Does your child get "cold sores" or "fever blisters"?
Yes No Does anyone in the family get "cold sores" or "fever blisters"?
Yes No Does anyone in the family have missing teeth?
Yes No City water
Yes No Fluoride supplement dosage ______________
Yes No Fluoridated toothpaste
Yes No Breastfed/when stopped ______________
Yes No Bottle/when stopped ______________
Yes No Pacifier/when stopped ______________
Yes No Is your child assisted in brushing?
Yes No Is your child assisted in flossing?
Yes No Are disclosing solutions used?
How often are your child's teeth brushed? ______________
How often are your child's teeth flossed? ______________
Yes No Has your child inherited any dental conditions? ______________________
Yes No Has your child ever had a dental injury (bumped or chipped tooth, bruised lip, etc.)? If yes, please explain ______________

____

Is there any other information you would like us to know prior to your child's visit? ______________________

____

The information listed on both sides of this form is complete and accurate. I give consent for Dr. Johnson, Dr. Morris, Dr. Byrd, and staff to perform a dental examination, dental prophylaxis, fluoride treatment and take x-rays on my child.

______________________ ______________

Parent/Guardian Date

Dentist notes: ______________________

- -

Specialists in Dentistry for Infants, Children, Teens and Children with Special Needs

OFFICE HOURS Monday - Friday 6:45am - 5:00pm