

Eastern Orthodontics & Pediatric Dentistry

Pediatric Dentistry

General Dentistry

Orthodontics

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THE FOLLOWING INFORMATION & HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT & UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name _____ Preferred Name _____ Age _____
Sex _____ Race _____ Date of Birth _____ Patient's Social Security # _____
Mailing Address _____ Home Phone # _____
Street City State Zip
Father's Name _____ Birthdate _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Where Employed _____
Mother's Name _____ Birthdate _____
Home Phone # _____ Work Phone # _____ Cell Phone # _____
Where Employed _____
Phone numbers for confirmation of appointment _____
Who is responsible for the account _____
Family Dentist _____ Date of Last Cleaning _____
Address _____ Patient's Physician _____
Whom may we thank for referring you to our office: Doctor Parent Patient _____
Name of person referring patient _____
Address City State Zip

MEDICAL HISTORY

YES NO Is the Patient in good health?
YES NO Does Patient have any history of major illness? _____
YES NO Has the Patient ever been under the care of a physician for illness?
Please list: _____

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED:

- Diabetes Rheumatic Fever Asthma Endocrine Problems Fainting or Dizziness
- Pneumonia Anemia Kidney Involvement Blood Disorders Nervous Disorders
- Heart Trouble Epilepsy Liver Involvement Bone Disorders Tuberculosis
- Other _____

YES NO Does Patient have a tendency to: Colds Sore Throats Ear Infections

YES NO Have tonsils and adenoids been removed? What age? _____

List any drugs or medications now being taken (give reasons): _____

List any allergies or drug sensitivity: _____

List any infectious diseases: _____

DENTAL HISTORY

YES NO Has there been injury to the face, mouth or teeth?
YES NO Does patient have any speech problems? _____
YES NO Is patient a mouth breather? While awake? While Asleep?
YES NO Has the patient been informed of any missing or extra permanent teeth?
YES NO Has an orthodontist been consulted previously?
YES NO Does the patient require antibiotic coverage for dental work?

List any musical instruments played: _____

Reason for consultation: _____

I agree to diagnostic procedures and dental treatments as found necessary and described by W. Lee Lewis, D.D.S. for the patient named above.

I will accept responsibility for this account or any part thereof should named responsible party fail to pay the full bill.

Signature of responsible party: _____ Date _____
_____ Dental assistant reviewing history