Eastern Orthodontics & Pediatric Dentistry

Jasper L. Lewis, Jr., D.D.S., P.A.

Pediatric Dentistry
Jasper L. Lewis, Jr., D.D.S., M.S.
Joseph M. Gondrez, D.M.D. · W. Lee Lewis, D.D.S.

General Dentistry
James T. Casey, II, D.D.S.
Scott O. LaFevers, D.D.S.

Orthodontics
W. Lee Lewis, D.D.S.

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

Patient's Name _____ **Preferred Name** _____ **Age** _____

Sex _____ Race _____ Date of Birth _____ Patient's Social Security # _____

Patient's Address _____ Home Phone # _____
Street City State Zip

Patient's Dental Insurance _____ Policyholder Name _____

Father's Name _____ Birth Date _____ Social Security # _____

His Address _____ Cell Phone # _____
Street City State Zip

Where Employed _____ Work Phone # _____

Mother's Name _____ Birth Date _____ Social Security # _____

Her Address _____ Cell Phone # _____
Street City State Zip

Where Employed _____ Work Phone # _____

Phone numbers for confirmation of appointment _____

Email address _____

With whom does Patient live? _____

Other children in Family (names & ages) _____

Child's Physician _____ Family Dentist _____

Whom may we thank for referring you to our office: □ Doctor □ Parent □ Patient _____
Name of person Referring Patient

_____
Address—Street or RFD City State Zip

YES NO *Child's weight* _____

- □ □ Is your Child in good health?
- □ □ Is your Child up to date with immunizations?
- □ □ Does your child have any allergies? If so, indicate below:
  Medicines? Yes □ No □ If so, what? _____
  Nuts/Tree Nuts? Yes □ No □
  Latex Allergy? Yes □ No □
  Seasonal Allergies? Yes □ No □
  Other? Yes □ No □ If so, what? _____
- □ □ Is your Child presently taking medicine?
  If so, what? _____
- □ □ Has your Child experienced any unfavorable reaction to medicine?
  If so, what? _____
- □ □ Is your Child presently undergoing medical treatment?
  If so, what? _____
- □ □ Has your Child been hospitalized since birth?
  Date _____ Reason _____
- □ □ Does your Child have any infectious diseases?
  If yes, list _____

HEALTH HISTORY

YES	NO	Has your child experienced:
□	□	Chronic cough
□	□	Night sweats
□	□	Chronic Fatigue
□	□	Recurrent Mouth Sores
		Has your child ever had:
□	□	Blood transfusions
□	□	Chemotherapy
□	□	Transplant surgery
□	□	General Anesthesia
□	□	Injury to mouth, head, teeth
□	□	Problem getting or losing teeth
□	□	Orthodontic treatment
□	□	Dental x-rays

Check any of the following that may pertain to your child:

- □ ADHD/ADD
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Autism
- □ Bladder
- □ Bleeding Disorder
- □ Bones/Joints
- □ Brain Injury
- □ Cancer
- □ Cerebral Palsy
- □ Chicken Pox
- □ Chronic Sinusitis
- □ Diabetes
- □ Ear Aches
- □ Emotional Disorder
- □ Epilepsy
- □ Fainting
- □ Growth Problems
- □ Hearing
- □ Heart
- □ Hepatitis
- □ HIV +/AIDS
- □ Immunizations
- □ Kidney
- □ Liver
- □ Lung Problem
- □ Measles
- □ Mental Disorder
- □ Mononucleosis
- □ Mumps
- □ Nervous Disorder
- □ Retardation
- □ Rheumatic Fever
- □ Seizures
- □ Sickle Cell Anemia
- □ Speech Disorder
- □ Thyroid
- □ Tobacco/Drug Use
- □ Tuberculosis
- □ Vision Disorder
- □ Other

What is your water source? □ Private Well □ Public System Name of system _____

YES NO

- □ □ Is this your child's first dental visit?
  If not, date of last dental care: _____
- □ □ Has your child had an unfavorable experience in a dental office?
- □ □ Does your child have a toothache?
  Purpose of appointment: _____

YES NO

- □ □ Is your child a finger sucker?
- □ □ Does your child use a pacifier?
- □ □ Was your child bottle fed?
  Age discontinued: _____
- □ □ Was your child breast fed?
  Age discontinued: _____

Thank you for your help. If there is any information that you can think may be of value to us in treating your child, please feel free to comment:

_____

_____

I agree to diagnostic procedures and dental treatments as found necessary by Jasper L. Lewis, Jr., D.D.S., M.S. or doctors working with Jasper L. Lewis, Jr., D.D.S., M.S., for the patient named above. I will accept responsibility for this account or any part thereof should responsible party fail or insurance benefit be denied or insufficient to pay the full bill.
Signature of responsible party: _____ Date _____

_____ Dental assistant reviewing history prior to doctor's review of history.

HEALTH HISTORY