PEDIATRIC DENTISTRY of
MIDDLE TENNESSEE, PLLC

STEPHEN SIMPSON,DDS,MS
CREATING HAPPY SMILES

Welcome to Dr. Stephen E. Simpson's Office

Thank you for giving us the privilege of caring for your child. We are pleased to provide the best possible care. Answers to these questions will help us make this possible.

Patient Information:

Child's Name: First_____ Middle_____ Last_____ Preferred Name:_____ Sex: M or F

DOB:_____ SS#_____ Who may we thank for referring you? _____

Any Family member currently undergoing dental care at Dr. Simpson's office?_____

Parent/Guardian Information:

Father's Name:_____ DOB:_____SS#:_____

Address:_____City/ State/Zip:_____ Apt #:_____

Home #:(___)_____ Cell #:(___)_____ Work #:(___)_____

Employer:_____ Email:_____

Mother's Name:_____ DOB:_____ SS#:_____

Address:_____City/ State/Zip:_____ Apt #:_____

Home #:(___)_____ Cell #:(___)_____ Work #:(___)_____

Employer:_____ Email:_____

Marital Status: Married____ Divorced____ Widowed____ Single____

For confirming appointments, which phone number do you prefer?_____

Insurance Information:

Insured Name:_____ ID#:_____ Group #:_____

Name of Dental Insurance Company: _____ Phone #:_____

Mailing Address of Insurance Company:

Child's Medical History:

Is your child in good health? Y or N

Is your child allergic to any drug or food? Y or N Explain:_____

Does your child have a heart murmur or history of heart murmur? Y or N Cardiologist:_____

Does child require antibiotics prior to dental treatment? Y or N Explain:_____

Is your child under medical care at this time? Y or N Explain:_____

Does your child have any conditions which might affect their dental treatment? Y or N Explain:_____

Is there any history of excessive bleeding in the child or family? Y or N Explain:_____

Child's Medical History: (Continued)

Please circle if your child has had problems with any of the following:

Heart Surgery	Diabetes	Liver	Hearing	Ulcers
Heart Murmur	Asthma	Kidney	Epilepsy	Hemophilia
Rheumatic Fever	Allergies	Cleft Lip/Palate	Sinuses	Acid Reflux
HIV/AIDS	Anemia	Cancer-Chemo therapy	Eye Problems	Irritable Bowel Syndrome
Hepatitis	ADHD	Fever Blisters	Blood Transfusion	Congenital Heart Defect

Autism or any other mental/emotional disorder Explain:_____

Other:_____

Has any of your immediate family had problems with any of the above? Y or N Explain:_____

Has your child ever been hospitalized? Y or N Hospital/Date/Reason_____

Please describe any other medical information we should be aware of that we have not discussed:_____

_____

Child's Dental History:

Does your child receive routine check-ups at your family dentist? Y or N Family Dentist:_____

Is today your child's first visit to a dentist? Y or N If no, please list date of last visit_____

What was done for your child at that time? _____ Were X-rays taken? Y or N

Does your child have a history of sucking their fingers? Y or N Thumb? Y or N Pacifier? Y or N Is the habit still active? Y or N

Is your child currently undergoing orthodontic treatment? Y or N Orthodontist:_____

Is your water supply fluoridated? Y or N (Consolidated Utility and Murfreesboro City water is fluoridated) Does your child drink bottled water? Y or N Does your child receive any fluoride supplements? Y or N If so, what? _____

Does your child brush their own teeth? Y or N If so, how often?_____ Floss? Y or N If so, how often?_____

Please circle any of the following concerns your child's teeth:

Cavities	Sensitive to hot & cold	Crooked	Toothache	Gum infection
Color of teeth	Sensitive to sweets	Bumped or broken	Cracked	Abscess

Permission:

Since _____is a minor, it becomes necessary that signed permission obtained from the parent or guardian before any and/or all necessary dental services (ex. All procedures and any and all use of drugs that are agreed to be necessary or advisable) can be performed by Dr. Stephen E. Simpson. Authorization is hereby granted as such. Furthermore, by signing this, I/we agree to be responsible for full payments of the charges for dental services performed on the above named patient regardless of assignment of insurance benefits. Should it be necessary to take action to collect any amount owing under this agreement, I/we agree to assume the costs incurred to collect including but not limited to collection agency fees, attorney fees and court costs.

Signed:_____ Date:_____Relationship_____