ELIZABETH S. WHITE, D.M.D., M.S., P.C.
102 METRO DRIVE
DOTHAN, ALABAMA 36303

TODAY'S DATE _____

Thank you for completing the following confidential information.

YOUR CHILD:

FULL NAME _____ NAME CHILD PREFERS _____ PHONE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MAILING ADDRESS (IF DIFFERENT) _____ EMAIL _____

SEX _____ BIRTHDATE _____ AGE _____ SCHOOL _____ GRADE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONFIRM APPOINTMENTS WITH BETWEEN 8 AM - 5 PM: _____ PHONE _____ CELL/PAGER _____

IF UNAVAILABLE, ALTERNATE PERSON TO CONTACT: _____ PHONE _____ CELL/PAGER _____

____ **MOTHER** ____ STEPMOTHER ____ GUARDIAN ____ GRANDMOTHER

NAME _____ HOME PHONE _____

WORK PHONE _____ EXT _____ EMPLOYER _____ POSITION _____

DATE EMPLOYED _____ CELLULAR PHONE _____ BEEPER _____ MARITAL STATUS _____

DRIVER'S LICENSE NUMBER _____ SSN: _____ BIRTHDATE _____

ADDRESS (If different from child) _____

____ **FATHER** ____ STEPFATHER ____ GUARDIAN ____ GRANDFATHER

NAME _____ HOME PHONE _____

WORK PHONE _____ EXT _____ EMPLOYER _____ POSITION _____

DATE EMPLOYED _____ CELLULAR PHONE _____ BEEPER _____ MARITAL STATUS _____

DRIVER'S LICENSE NUMBER _____ SSN: _____ BIRTHDATE _____

ADDRESS (If different from child) _____

PRIMARY DENTAL INSURANCE: Our office does not file Secondary Insurance claims. If you have two dental coverages, the primary belongs to the parent whose birthday is earliest in the year.

EMPLOYEE'S FULL NAME AS IT APPEARS ON DENTAL INSURANCE CARD _____

DENTAL INSURANCE COMPANY _____

INSURANCE COMPANY ADDRESS _____

INSURANCE COMPANY PHONE _____ GROUP NUMBER _____ CONTRACT NUMBER _____

Method of Payment:

____ CASH ____ CREDIT CARD ____ PERSONAL CHECK

____ PRIMARY INSURANCE (Deductibles, co-pays and non-covered charges are due at the time services are rendered)

DENTAL HISTORY

	YES	NO
Date of last visit to a dentist _____		
Name of previous dentist _____ City _____		
For what service _____	YES	NO
Were x-rays taken _____	☐	☐
Has child complained about dental problems or has parent noticed spots or chipped areas on teeth _____	☐	☐
Any unhappy dental experiences _____	☐	☐
_____		
Any injuries to mouth - teeth - head _____	☐	☐
_____		
Any mouth habits - thumbsucking, nail biting, mouth breathing, nursing bottle habits, sippy cup, pacifier, etc. _____	☐	☐
Previous/current speech therapy _____	☐	☐
Previous/current orthodontic treatment _____	☐	☐

	YES	NO
Does your child brush teeth daily _____	☐	☐
Do you assist child with tooth brushing _____	☐	☐
How often _____		
Is dental floss used _____	☐	☐
How often _____		
Are disclosing tablets used _____	☐	☐
Is fluoride taken in any form _____	☐	☐
Is drinking water fluoridated _____	☐	☐

Child's attitude to dentistry:

___very nervous ___mildly nervous

___comfortable ___very comfortable

Parent's attitude to dentistry:

___very nervous ___mildly nervous

___comfortable ___very comfortable

Do you desire complete dental service for your child? _____ ☐ ☐

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY