WILKINSON ORTHODONTICS AND CHILDREN'S DENTISTRY

5610 Murray Ave, Memphis, TN 38119
901-767-3390 Fax: 901-763-0465

Patient Information

Child's Name:____ Preferred Name:_______________ Sex: M F
Date of Birth:___________ School:____
Physician:____Date of last medical exam:_________________
Who referred you to our office? (Dentist, patient, internet)____

Medical History

Is your child in good health? Yes No
Has your child had or does he/ she have now:

Diabetes……………………………………Yes No
Hearing loss…………………………...….Yes No
Cleft lip or palette………………………..…Yes No
Hepatitis………………………….................Yes No
Rheumatic fever………………….................Yes No
Difficulty with speech………….................Yes No
Cerebral Palsy………………………..…..Yes No
Leukemia………………………………...….Yes No
Mouth injuries……………………………....Yes No
Asthma or lung problems…………………...Yes No
Tumor or malignancies……………………..…Yes No
ADD/ ADHD…………………………..…...Yes No
Kidney problems…………………………..…..Yes No
Finger/ thumb/ pacifier sucking…................Yes No

Emotional, mental or nervous problems……Yes No
Birth defects………………………………Yes No
If so what?_____________________________
Heart disease or murmur……………………Yes No
Food or pollen allergies……………………...Yes No
If so what?_____________________________
Allergy to medications………………………Yes No
If so what?_____________________________
Epilepsy or any seizure disorder…………….Yes No
Prolonged bleeding or hemophilia…………..Yes No
Any reason local anesthetic cannot be used? Yes No
Is your child taking medication now?.............Yes No
Is your child under medical care at this time? Yes No
If yes, please explain:______________________________
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Dental History:

Is this your child's first visit to our office? Yes No Has your child been seen in any other Dental office? Yes No
If so where?____
What is your main concern for this visit?____
Date of last Dental exam:___________________ Date of last X-rays:___________________________
Has your child experienced any unfavorable reaction from any previous medical or dental care? Yes No
If so what?____
Does your child brush every day? Yes No Do you assist with brushing and/ or flossing? Yes No
Is your child still breast or bottle feeding? Yes No
Family Dentist:____Phone:______________________

Billing Information:

Primary guardian's complete name:___________________________________ SSN:___________Cell Phone:_______________
Home address:__________________________________City:____________State:____Zip:_______ Home :_________________
Date of birth:_________________ Relation to patient:________________________ Work Phone:__________________________
Secondary guardian's complete name:__________________________________ SSN:______________Cell Phone:_____________
Home address:__________________________________City:____________State:____Zip:_______ Home:__________________
Date of birth:________________ Relation to patient:________________________ Work Phone:__________________________
Are parents divorced, separated, remarried or deceased? Yes No If yes, explain:____

Dental Insurance

Carrier:_________________Address:____Phone:_____________
Insured's Name:__________________________Date of Birth:_________Group #: ____________________
Member ID: __________________________ Employer:____
Name of person to contact in case of emergency (not living at home):____
Relation to patient:____Phone:___________________________

The undersigned hereby authorizes this dental office to perform the examination and, after explanation, the necessary dental services deemed appropriate for the care of the above child and furthermore, will be responsible for charges incurred from said dental patient.

In the event of non-payment resulting in this Dental office referring my account to an attorney or collection agency, I agree to pay and indemnify Gregory T. Wilkinson D.D.S. against all legal costs and charges incurred by the doctor.

Parent Signature:____Date:____________________________