Southpoint Pediatric Dentistry

Amy C. Davidian, DDS, PA

3 Year Demographic and Health History Update

Patient			Today's Date		
First	MI	Last	,		
Name child would like	to be called		Home Phone		
Birthday	Age	_Sex_	Cell Phone		
Interested in email ap	pointment confir	mations? Yes or	No Parent Email:		
	-				
School					
Home Address					. ,
street			town	state z	zip code
HAS YOUR DENTAL	INSURANCE CHA	NGED SINCE Y	OUR LAST VISIT?	YES NO	
If yes , please update					
• •	_	DO	SS#_		
Insurance Company		Gro	up#ID#		
. ,					
Please advis	se us of any chan	ges in your chil	d's medical health since	e your last visit	
	•	,		•	
? Yes ? No	Is your child in go	ood health? Date	e of last physical exam		
2 Yes 2 No	,		ges since your child's las		
		,	,		
2 Yes 2 No	Has your child been hospitalized in the last 3 years? Please give reason & dates				
	,	,	,	J	
2 Yes 2 No	Is your child aller	raic to anythina?)		
2 Yes 2 No	Is your child allergic to anything?				
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	-			-	
	-			-	
Please mark if your ch	uild has been trea	ted for any of tl	ne followina:		
·		•	-	= MDC 4	
AIDS/HIV Advance drive recetions		- /	resight	☑ MRSA	امنما
Adverse drug reactionsAnemia		•	Prequent infections art disease/murmur	Personality/s □ Physical delays	ιοιαι
	© Cleft lip/	•		Physical delays	
2 Asthma/breathing	_	al birth defects	Proportities Proportities	2 Rheumatic fe	sver.
2 Autism	Diabetes		☑ Kidney disease	2 Seizures	
Bleeding/transfusions	Down's Sy		2 Liver/GI disease	Significant in	•
Blood dyscrasias	2 Endocrine	e/growth	Mental delays	Speech/hear	_
5 1 1 1 .				Other proble	2ms
Please elaborate on any	items marked abo	ove:			
WE CARE!!! Please inf	orm us of any SPE	CIAL NEWS abo	out your child		

Southpoint Pediatric Dentistry Amy C. Davidian, DDS, PA

I give permission to the following people to bring my child to his/her future appointments:

Consent for Dental Treatment

I request and authorize Dr. Amy C. Davidian, Dr. Martha Holland, and Dr. Mark Cummings to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by the dentist to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Amy C. Davidian, Dr. Martha Holland, and Dr. Mark Cummings will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature	Date
Legal GuardianYESNO	If no , what is your relationship to patient?

**Just a friendly reminder-we value the privacy of our little patients and their families. We ask that you please avoid the use of all picture and recording devices within our office.* *