Welcome

It is our mission to assist patients and parents in establishing a "dental home" through education and comprehensive, child-appropriate care that promotes cavity prevention and builds the foundation for a life-long understanding of good dental hygiene and health.

WENDELL HOLDBROOK, DMD
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Patient Information

Social Security Number: _____

Child's Name: _____ Nickname: _____ Birth Date: _____

Home Address: _____ City: _____ State: _____ ZIP: _____

Home Phone: _____ Child's Interests: _____

Child's School: _____ Child's Grade: _____

Father's/Guardian's Name: _____ Father's/Guardian's Social Security#: _____

Father's/ Guardian's Address (if different): _____

Phone: _____ Cell Phone: _____

Father/Guardian Employed by: _____ Phone: _____

Present Position: _____ How Long Held: _____

Father's/ Guardian's Dental Insurance: _____ Birth Date: _____

Identification #: _____ Group #: _____ Effective Date: _____

Mother's/Guardian's Name: _____ Mother's/Guardian's Social Security#: _____

Mother's/ Guardian's Address (if different): _____

Phone: _____ Cell Phone: _____

Mother/Guardian Employed by: _____ Phone: _____

Present Position: _____ How Long Held: _____

Mother's/ Guardian's Dental Insurance: _____ Birth Date: _____

Identification #: _____ Group #: _____ Effective Date: _____

Who is responsible for this account? (which parent and/or guardian?): _____

Other Children in Family? (names and ages): _____

Whom may we thank for referring your child? _____

Do you desire **ROUTINE DENTAL CARE** for your child? _____ ☐ YES ☐ NO

E-mail address where you wish to be contacted: _____

Please outline any parental and/or guardianship issues: _____

_____

Our Office is **HIPAA** compliant for your child's privacy.
We are committed to meeting or exceeding the ADA infection control standards.

Please Complete Reverse Side

Child's Name (Last, First): _____ Date of Birth: _____

Medical History

Primary Physician's Name: _____ Practice Name (if different): _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Purpose and Date of Last Exam:_____

Does child receive REGULAR medical "well checks"? ☐ YES ☐ NO

Is child current on immunizations? ☐ YES ☐ NO If not, please note the reason: _____

Do any of these conditions affect your child's health?

Physical Disability	Y	N	Kidney/Liver Problems	Y	N
Seizures/Epilepsy	Y	N	Asthma	Y	N
Tuberculosis	Y	N	Rheumatic Fever	Y	N
HIV / AIDS	Y	N	Heart Murmur	Y	N
Diabetes	Y	N	Congenital Birth Defect	Y	N
Hepatitis	Y	N	Congenital Heart Defect	Y	N
Cancer	Y	N	Abnormal Blood Pressure	Y	N
Allergy to Penicillin	Y	N	Bleeding Disorder	Y	N
Allergy to Drugs	Y	N	Psychiatric Therapy	Y	N
Allergy to Local Anesthetic	Y	N	Learning Disability	Y	N
Allergy to Latex	Y	N	Hearing Disability	Y	N

Are there ANY other conditions Dr. Holdbrook should be aware of?: _____

_____

Is your child taking ANY medications presently? ☐ YES ☐ NO Purpose: _____

Please list any specialist physician(s) who are treating your child (name/address/phone/type of specialty/last visit):

_____

_____

Dental History

Does your child brush daily?	Y	N	How often (times per day) _____
Do you assist your child in brushing?	Y	N	How often _____
Do you floss your child's teeth?	Y	N	How often _____
Does your child take a fluoride vitamin or supplement?	Y	N	How often _____
Does your child have any mouth habits?	Y	N	Describe: _____
(thumb or finger sucking, pacifier use, nail biting, chewing pencils, etc.)			_____
Does your child take a bottle or sippy cup to bed?	Y	N	If yes, what contents? _____
Does your child have a history of cold sores/fever blisters?	Y	N	Describe: _____
Has your child complained about or shown symptoms of dental problems (pain, fingers in mouth, etc.)?	Y	N	Describe: _____
How recently? _____			
At what age did your child's first tooth arrive? _____			
Has your child HAD ANY bad dental experiences?	Y	N	Describe: _____
_____			
Has your child HAD ANY injuries to the mouth or head?	Y	N	Describe: _____
_____			

This information was given by (please sign & date): _____ Date: _____

I authorize Holdbrook Pediatric Dental, LLC and its employees to perform any required dental services for my child and hereby give parental permission to take any necessary radiographs.