WENDELL HOLDBROOK, DMD
Certified American Board of Pediatric Dentistry
Spec. # 5838

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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.

Patient Information

Patient's Social Security # _____
Child's Name _____ Nickname _____ Birthdate _____
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 Address (if different) _____
Phone _____ Cell Phone _____
Father/ Guardian Employed by _____ Phone _____
Present Position _____ How Long Held _____
Father's Guardian's Dental Insurance _____ Birthdate _____
Identification # _____ Group # _____ Effective Date _____

Mother's/ Guardian's Name _____ Father's/Guardian's Social Security # _____
Mother's/ Guardian Address (if different) _____
Phone _____ Cell Phone _____
Mother/ Guardian Employed by _____ Phone _____
Present Position _____ How Long Held _____
Mother's Guardian's Dental Insurance _____ Birthdate _____
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 _____ Date of Birth _____
(Last, First)

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
Autism	Y	N	Down syndrome	Y	N
Mental Retardation	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 _____ _____
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.