George Adams, Jr. D.M.D. Ryan Seaton, D.D.S.
O: 615-297-7597 ● **F:** 615-269-7132
4515 Harding Pike #114, Nashville, TN 37205
info@AdamsPediatricDentistry.com ● www.adamspd.com

NEW PATIENT FORM

Patient Health History

These questions are of great value in aiding us to a better understanding of your child.

Child's Name: _____ Nickname, if any: _____ Sex: □ M □ F
Age: ___ Birthday: _____ Place of Birth: _____
Attends Which School: _____ Grade: _____
Name and Ages of Brothers: _____
Name and Ages of Sisters: _____
Child's Physician or Pediatrician: _____ Date of Last Visit: _____
Family Dentist: _____ Referred by Whom: _____
Purpose of Visit Today: _____ Name of Child's Pet or Hobbies: _____
Patient's SSN: _____

Is your child in good health? □ Yes □ No	Check all that apply to your child:
Does your child have regular medical exams? □ Yes □ No	□ Seasonal Allergies □ Versed Allergy
Is your child up to date with immunizations? □ Yes □ No	□ Asthma □ Allergic to _____
Is this your child's first dental visit? □ Yes □ No	□ Emotional Disorder □ Hearing Disorder
Date of last visit: _____	□ Liver Disorder □ Mental Disorder
Is your child a thumb sucker? □ Yes □ No	□ Nerve Disorder □ Sensory Disorder
Did your child use a pacifier? □ Yes □ No	□ Speech Disorder □ Vision Disorder
If your child was bottle-fed, at what age was it discontinued? ___	□ Anemia □ Sickle Cell Anemia
Is your child presently taking any medication? □ Yes □ No	□ Heart Condition □ Kidney Disease
Medications: _____	□ Respiratory Problems □ Brain Injury
Does your child have any allergies to medication? □ Yes □ No	□ Intellectually Challenged □ Epilepsy/Seizures
Medications: _____	□ Spina Bifida □ Autism
Is your child presently undergoing medical treatment? □ Yes □ No	□ ADD/ADHD □ Asperger's
Has your child ever had an unfavorable experience in	□ Down Syndrome □ Cerebral Palsy
a dental office? □ Yes □ No	□ Cleft Lip/Palate □ Wheelchair Bound
Does your child have a toothache? □ Yes □ No	□ Tuberculosis □ Hepatitis
Is your child adopted? □ Yes □ No	□ Diabetes □ Cancer _____
Has your child ever had general anesthesia? □ Yes □ No	□ Pregnancy □ Other _____

Father: _____ DOB: _____ SSN: _____
First Middle Last
Mother: _____ DOB: _____ SSN: _____
First Middle Last
Home Address: _____ Phone: _____
Street City State Zip
Father Employed: _____ Cell Phone: _____
Business Address _____ Marital Status: _____
Mother Employed: _____ Cell Phone: _____
Business Address: _____ Marital Status: _____
Person to contact locally in case of emergency, other than parents: _____ Phone: _____

Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any/ or all necessary dental service can be started and accomplished by Dr. Adams Jr and/or Dr. Seaton.

Authorization is hereby granted as such; furthermore, I will be responsible for any bill incurred on this child for dental treatment.

Person responsible for the account: _____ (must be present at first visit)

I authorize and request my insurance company to pay directly to the dentist those insurance benefits otherwise payable to me.

Name of Dental Insurance: _____

Signature: _____ Date: _____