ADAMS & SEATON
PEDIATRIC DENTISTRY

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@adamsandseaton.com ● www.adamsandseaton.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: ____________________________ SSN: __________________
Current 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: ______________________

Is your child in good health?	□ Yes □ No
Does your child have regular medical exams?	□ Yes □ No
Is your child up to date with immunizations?	□ Yes □ No
Is this your child's first dental visit?	□ Yes □ No
Date of last visit: __________________________________	
Is your child a thumb sucker?	□ Yes □ No
Did your child use a pacifier?	□ Yes □ No
If your child was bottle-fed, at what age was it discontinued? ___	
Is your child presently taking any medication?	□ Yes □ No
Medications: ______________________________________	
Does your child have any allergies to medication?	□ Yes □ No
Medications: ______________________________________	
Is your child presently undergoing medical treatment?	□ Yes □ No
Has your child ever had an unfavorable experience in a dental office?	□ Yes □ No
Does your child have a toothache?	□ Yes □ No
Is your child adopted?	□ Yes □ No
Has your child ever had general anesthesia?	□ Yes □ No

Check all that apply to your child:

□ Seasonal Allergies	□ Versed Allergy
□ Asthma	□ Allergic to __________
□ Emotional Disorder	□ Hearing Disorder
□ Liver Disorder	□ Mental Disorder
□ Nerve Disorder	□ Sensory Disorder
□ Speech Disorder	□ Vision Disorder
□ Anemia	□ Sickle Cell Anemia
□ Heart Condition	□ Kidney Disease
□ Respiratory Problems	□ Brain Injury
□ Intellectually Challenged	□ Epilepsy/Seizures
□ Spina Bifida	□ Autism
□ ADD/ADHD	□ Asperger's
□ Down Syndrome	□ Cerebral Palsy
□ Cleft Lip/Palate	□ Wheelchair Bound
□ Tuberculosis	□ Hepatitis
□ Diabetes	□ Cancer ___________
□ Pregnancy	□ Other ___________

Father/Guardian: ____ DOB: ____________ SSN: _______________
First Middle Last
□ Single □Married □Separated/Divorced Employer: ________________________________ Cell Phone: _______________

Mother/Guardian: ____ DOB: ____________ SSN: _______________
First Middle Last
□ Single □Married □Separated/Divorced Employer: ________________________________ Cell Phone: _______________

Home Address: ____ Phone: _______________
Street City State Zip

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 Company: ____

Signature: ____ Date: _______________