



GOODLETTSVILLE

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GOODLETTSVILLE, TN 37072
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NASHVILLE

2011 CHARLOTTE AVE
SUITE A
NASHVILLE TN, 37203
PHONE: 615.327.0322
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www.ourkidzcare.com

MT. JULIET

5003 CROSSING CIRCLE
SUITE 100
MT. JULIET, TN 37122
PHONE: 615.5534125
FAX: 615.553.4133

PATIENT'S NAME _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ AGE _____ SEX _____ SCHOOL _____

PATIENT'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

FATHER'S NAME _____ DOB _____ SOCIAL SECURITY # _____

MARTIAL STATUS: SINGLE () MARRIED () SEPARATED () DIVORCED () WIDOWER () OTHER () _____
FATHER STEPFATHER GUARDIAN

FATHER'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

FATHER'S HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

FATHER EMPLOYED BY _____ OCCUPATION _____ EMAIL ADDRESS _____

MOTHER'S NAME _____ DOB _____ SOCIAL SECURITY # _____

MARITAL STATUS: SINGLE () MARRIED () SEPARATED () DIVORCED () WIDOWED () OTHER () _____
MOTHER STEPMOTHER GUARDIAN

MOTHER'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

MOTHER'S HOME PHONE _____ BUSINESS PHONE _____ CELL PHONE _____

MOTHER EMPLOYED BY _____ OCCUPATION _____ EMAIL ADDRESS _____

NAME AND NUMBER OF NEAREST RELATIVE OR FRIEND, NOT AT THE ABOVE ADDRESS _____

WHOM MAY WE THANK FOR REFERRING YOU TO THIS OFFICE? _____

NUMBER OF CHILDREN _____ AGES _____ DENTAL CARRIER _____

PATIENT'S MEDICAL HISTORY ONLY. NOT FAMILY HISTORY. Please check all conditions that apply:

- | | | | | | |
|--|--|--|---|---|---------------------------------|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> BLEEDING DISORDER | <input type="checkbox"/> SCARLET FEVER | <input type="checkbox"/> CLEFT LIP/
PALATE | <input type="checkbox"/> OTHER: |
| <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> NERVOUS
DISORDER | <input type="checkbox"/> PREGNANT | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> HEPATITIS | |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> THYROID
DISORDER | <input type="checkbox"/> SPECIAL DIETS | <input type="checkbox"/> CANCER | <input type="checkbox"/> ANEMIA | |
| <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> RHEUMATIC FEVER | <input type="checkbox"/> IMMUNE
DEFICIENCY | <input type="checkbox"/> NONE | |
| <input type="checkbox"/> STOMACH DISORDER | <input type="checkbox"/> CLOIC | <input type="checkbox"/> FREQUENT COLDS | <input type="checkbox"/> SINUSITIS | <input type="checkbox"/> SHORTNESS OF
BREATH | |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> HAY FEVER | <input type="checkbox"/> BLOOD DISEASE | |
| <input type="checkbox"/> TUBERCULOSIS | | | <input type="checkbox"/> BLOOD DISEASE | | |
| <input type="checkbox"/> CHRONIC COUGH | | | | | |

IS YOUR CHILD OR ADOLESCENT TAKING ANY MEDICATIONS AT THIS TIME? Y / N
IF YES, WHAT KIND? _____

DOES YOUR CHILD HAVE A MENTAL HANDICAP? Y / N **DOES YOUR CHILD HAVE ANY PHYSICAL HANDICAP? Y / N**

DOES YOUR CHILD OR ADOLESCENT HAVE ANY HISTORY OF ALLERGIES OR UNFAVORABLE REACTIONS TO OF THE FOLLOWING MEDICATIONS?

- | | | | |
|--------------------------------------|--|--|---------------------------------------|
| <input type="checkbox"/> PENICILLIN | <input type="checkbox"/> SULFA DRUGS | <input type="checkbox"/> LOCAL ANESTHETICS | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> AMOXICILLIN | <input type="checkbox"/> LATEX | <input type="checkbox"/> BARBITURATES | _____ |
| <input type="checkbox"/> ASPRIN | <input type="checkbox"/> CODEINE | | _____ |
| <input type="checkbox"/> AUGMENTIN | <input type="checkbox"/> GENERAL ANESTHETICS | | _____ |

NAME OF CHILD'S PHYSICIAN: _____ PHONE #: _____ DATE OF LAST EXAMINATION: _____

PLEASE SELECT THE REASON FOR YOUR VISIT TODAY

- | | | | | |
|---|--|---|--|---------------------------------|
| <input type="checkbox"/> ROUTINE
CHECKUP | <input type="checkbox"/> BLEEDING AROUND TEETH | <input type="checkbox"/> SWELLING OF FACE | <input type="checkbox"/> CROWDING OF TEETH | <input type="checkbox"/> OTHER: |
| <input type="checkbox"/> APPERANCE OF TEETH | <input type="checkbox"/> ACCIDENT TO TEETH | <input type="checkbox"/> TOOTHACHE | | |

HOW DO YOU FEEL YOUR CHILD WILL REACT TO THE DENTIST? _____ HAS YOUR CHILD VISITED A DENTIST BEFORE? _____
DOES YOUR CHILD RELATE WELL TO OTHER CHILDREN? _____ DOES YOUR CHILD RELATE WELL TO ADULTS? _____
DO YOU FEEL YOUR CHILD WILL NEED BRACES? _____ DO YOU FEEL YOUR CHILD WILL NEED SPECIAL CARE? _____

PARENT OR GUARDIAN SIGNATURE FOR MINOR CHILDREN _____ Relationship _____ Date _____

NOTE: No child under 18 years of age is to be left unattended. Parent or Guardian must be present during the duration of your visit. Or else no treatment will be done. **ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.**