Bryan Cobb, DDS, MS
Diplomate, American Board of Pediatric Dentistry

Pediatric Dentistry
2600 A Oakcrest Avenue, Greensboro, North Carolina 27408
(336) 288-9445 • (336) 288-9491 FAX
www.bryancobbdds.com

DATE___________________

GENERAL INFORMATION:

Father's Name____ S.S.#______________ DOB:________
First Middle Last

Home Address______________________________ City_____________ State______ Zip____________

How long at this address______ Home Phone___________ Marital Status____________________

Previous Address(if less than 3 yrs.)____

Occupation_________________ Employed by_____________________________ How Long_________

Business Address___________________ City___________ State_____ Zip_______ Phone__________

Mother's Name____ S.S.#______________ DOB:________
First Middle Last

Home Address______________________________ City_____________ State______ Zip____________

How long at this address____ Home Phone____________ Marital Status_____________________

Previous Address(if less than 3 yrs.)____

Occupation__________________ Employed by__________________________ How Long__________

Business Address___________________ City___________ State____ Zip________ Phone__________

Email____

Person responsible for account_____________________ Relationship to child______________

Address_________________________________ City___________ State_____ Zip_____ Phone______

Previous Address(if less than 3 yrs.)____

Do you have dental insurance? Yes_____ No________

If so, name of Insurance Company____________________________ Policy_____________________

Name of nearest relative not living with you____

Address________________________________ City___________ State___ Zip______ Phone_________

CHILD'S HISTORY:

Child's Name__________________________ Nickname________________ Sex____ SS#:____________

Address_______________________________ City_____________ State_____ Zip_______________

Date of Birth____________ Age_________ Weight_________ School__________________________

Names and ages of brothers and sisters____

Child's Physician or Pediatrician____

Family Dentist____

Whom may we thank for referring you?____

<u>IT IS IMPORTANT THAT ALL ITEMS BE COMPLETED</u>

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CHILD'S NAME____________________

MEDICAL HISTORY:

Has your child experienced any of the following?

	YES	NO		YES	NO
Allergies	____	____	Heart Disorder	____	____
Anemia	____	____	Hepatitis (type A or B)	____	____
Asthma or Hay Fever	____	____	Jaundice	____	____
Bleeding Disorders	____	____	Kidney or Liver Disease	____	____
Bronchitis	____	____	Lung Problems	____	____
Cerebral Palsy	____	____	Mental Disorder	____	____
Diabetes	____	____	Nervous Disorder	____	____
Epilepsy	____	____	Rheumatic Fever	____	____
Fainting	____	____	Seizures	____	____
Hearing Disorder	____	____	Speech Disorder	____	____
Other physical or mental disorders?			HIV (AIDS)	____	____

Has any immediate family member had any of the above?
Please describe____

Is child under care of a physician now?_____Reason____________________
Has child ever been hospitalized?____Reason____________________
LIST any drug or medicine allergies such as penicillin, aspirin or novocain________
____

LIST drugs or medicines presently being taken____________________

DENTAL HISTORY:
Do you want complete dental treatment for your child? Yes_____No_____
What is your main concern about your child's dental health?____________________
____
Has your child ever complained about a dental problem, or had any unhappy dental experiences? Yes_____No_____Please explain____________________
Is this your child's first visit to the dentist? Yes_____No_____
Date of last dental visit__________For what service____________________
Were any x-rays taken? Yes_____No_____
How do you expect your child to behave in our office?____________________
____

YES	NO	
____	____	Is your child having a dental problem right now?____________________
____	____	Has child had any unhappy dental experiences?
____	____	Any injuries to mouth, teeth, or head?
____	____	Any mouth habits (thumbsucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)?
____	____	Any unusual speech habits?
____	____	Orthodontic appliances worn now or ever?
____	____	Does your child brush his/her teeth daily?
____	____	Do you assist child with tooth brushing?
____	____	Is dental floss used?
____	____	Is fluoride taken in any form? How____________________

May we request release of your child's medical records? Yes_____No_____

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here:____________________
____