Pediatric Dental Specialists, PLLC

W. Neil Quinton, D. M. D.
Megan Gant, D.M.D.

1550 N Medical Park Dr.
Greenville, MS 38703

Office: (662)-334-9337
Fax: (662)-334-9897

PATIENT INFORMATION

Child's Name: _____ Nickname: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Legal Guardian Name: _____ Relationship to Patient: _____

Address: _____ City/State: _____ Zip: _____

Phone: _____ DOB: _____ SSN: _____

Employed By: _____ Position: _____ Work Phone: _____

Alternate Contact Name: _____ Relationship to Patient: _____

Address: _____ City/State: _____ Zip: _____

Phone: _____ Alternate Phone: _____

Employed By: _____ Work Phone: _____

Other Children in the family, and their ages: _____

Do you have dental insurance that may cover part of this professional service? _____

Were you referred? If yes, by who? _____

DENTAL HISTORY

What is your main dental concern? _____

Is this your child's first visit to the dentist? YES NO

Who was the last dentist seen? _____

Last date patient's teeth were cleaned _____

Has child complained about dental problems? YES NO

If yes, explain: _____

Any unhappy dental experiences? _____

_____

Any injuries to mouth, teeth, or head? _____

_____

Any mouth habit—thumb, pacifier, nail biting, etc.?

_____

Any lost teeth? YES NO

Does your child brush daily? YES NO

Do you help your child brush? YES NO

Is dental floss used? YES NO

Is fluoride taken in any form? YES NO

Do you have well water? YES NO

Any Comments, Requests, or Concerns:

_____

_____

_____

_____

_____

MEDICAL HISTORY

Child's Physician: _____ Address: _____ Phone: _____

Date of Last Physical: _____ Results: _____

Is child under the care of a physician now? _____

Is child receiving any medication or drugs? If so, please list: _____

Is there any excessive bleeding when cut? _____

Has child ever been hospitalized? If yes, please explain: _____

Has child ever had surgery? If yes, please list: _____

Is there any allergy to penicillin or other drugs? If yes, please list: _____

Does child have good physical coordination? _____

Are there any emotional issues? If yes, please explain: _____

Any history of problems with local/general anesthesia? _____

DOES CHILD HAVE ANY HISTORY WITH THE FOLLOWING:

☐ ADHD/ ADD	☐ Cerebral Palsy	☐ Hearing	☐ Rheumatic Fever
☐ Anemia	☐ Chronic Sinus	☐ Heart Murmurs	☐ Thyroid
☐ Anxiety/Depression	☐ Convulsions	☐ Kidney	☐ Tuberculosis
☐ Asthma	☐ Diabetes	☐ Liver/Hepatitis	☐ HIV/AIDS
☐ Autism	☐ Down Syndrome	☐ Malignancies	☐ Other, explain:
☐ Bladder	☐ Epilepsy	☐ Mononucleosis	_____

PERMIT FOR TREATMENT UPON A MINOR

Child's Name: _____ Age: _____

I, being the parent or guardian of the above minor patient, do hereby authorize and request the performance of dental services for this patient; and further, the performance of whatever procedures the judgment of the above named doctors may deem necessary during the performance of any dental treatment.

I also authorize the administration of anesthetics or analgesics which may be deemed advisable by the doctor, with my knowledge.

Furthermore, I will be responsible for any financial obligations incurred on this child for dental treatment. I also understand that payment for treatment rendered is expected at the end of each appointment, unless other financial arrangements are made.

Parent/Guardian Signature: _____ Date: _____