

# Welcome

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<b>Patient Information</b>		Date _____
Patient's Name _____ <small>First Middle Last</small>	Nickname _____	Sex _____
Street Address _____	Date of Birth _____	Age _____ Weight _____
Patient Social Security # _____	Child Lives with: <input type="checkbox"/> Both parents <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Other _____	
Names of brothers or sisters in practice _____	School Name _____	
Patient's Physician or Pediatrician Name _____	Family Dentist _____	
Whom may we thank for referring you? <input type="checkbox"/> Media <input type="checkbox"/> Doctor (name) _____	<input type="checkbox"/> Friend (name) _____	
<input type="checkbox"/> Website <input type="checkbox"/> Phone Book <input type="checkbox"/> Other _____		

<b>Responsible Party Information</b>		<input type="checkbox"/> Single <input type="checkbox"/> Separated
Name: _____ <small>First Middle Last</small>	Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
Residential Address _____ <small>Street City State Zip</small>		
Mailing Address _____ <small>Street City State Zip</small>		
How long at this address _____	Home Phone _____	Work Phone _____
Previous Address (if less than 3 yrs.) _____ <small>Street City State Zip</small>		
Social Security Number _____	Birthdate _____	Relationship to patient _____
Employer _____ <small>(if self-employed, list name of business)</small>	Occupation _____	No. Years Employed _____
Spouse's Name: _____	Relationship to Patient _____	
Employer _____ <small>(if self-employed, list name of business)</small>	Occupation _____	No. Years Employed _____
Social Security Number _____	Birthdate _____	Work Phone _____
Email Address _____	Approved ID _____	Issue Date _____

<b>Dental Insurance Information</b>		
Policy Holder's Name _____	Policy Holder's Soc. Sec. # _____	Birthdate ____ / ____ / ____
Insurance Co. _____	Group No. _____	Subscriber No. _____
Insurance Co. Address _____	Phone No. _____	
Policy Holder's Employer _____	Do you have other dental insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No	

<b>Emergency Information</b>		
Name of nearest relative not living with you _____	Phone No. _____	
Address _____ <small>Street City State Zip</small>	Relationship to patient _____	

I understand that where appropriate, credit bureau reports may be obtained.

Signed \_\_\_\_\_ Date \_\_\_\_\_

### Medical History

Does your child/teen have any of the following? Please circle.

Y N Allergies	Y N Fainting	Y N Pregnancy/Nursing
Y N Anemia	Y N Hearing Disorder	Y N Rheumatic Fever
Y N Asthma	Y N Heart Disease	Y N Seizures/Epilepsy
Y N Autism	Y N Hepatitis	Y N Special Needs
Y N Bleeding Disorder	Y N Kidney or Liver Disease	Y N Speech Disorder
Y N Diabetes	Y N Mental Disorder	Y N AIDS/HIV
Y N Cold/Virus	Y N Nervous Disorder	Y N Other _____

My child was born: (please check)  Less than 35 weeks  35-40 weeks  40+ gestation

Did you experience any problems during your pregnancy?  Yes  No If Yes, please describe: \_\_\_\_\_

Do any family members smoke around your child?  Yes  No

Has your child experienced any other physical or mental disorder that is not listed above?  Yes  No

If Yes, please describe: \_\_\_\_\_

Has any immediate family member had any of the above?  Yes  No If Yes, please describe: \_\_\_\_\_

Is your child allergic to any of the following drugs:

Y N Penicillin Y N Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs:  Yes  No If Yes, please list: \_\_\_\_\_

Is your child allergic to Latex, red dye or anything we need to be aware of?  Yes  No If Yes, list: \_\_\_\_\_

Is your child presently under the care of a physician for any illness?  Yes  No If Yes, please list: \_\_\_\_\_

List any drugs or medicines presently being taken: \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No If Yes, please give reason and date(s) \_\_\_\_\_

### Dental History

Do you want complete treatment for your child?  Yes  No

Why did you bring your child to see us today? \_\_\_\_\_

Is this your child's first visit to the dentist?  Yes  No Name of previous dentist: \_\_\_\_\_

Has your child ever had a serious/difficult problem associated with previous dental work?  Yes  No

If Yes, please explain: \_\_\_\_\_

Date of last dental visit: \_\_\_\_\_ For what service: \_\_\_\_\_

Were any x-rays taken?  Yes  No If Yes, have x-rays been sent to our office? \_\_\_\_\_

How do you expect your child to behave in our office? \_\_\_\_\_

Y N Does your child brush his/her teeth daily?

Y N Do you assist child with tooth brushing?

Y N Is dental floss used? — How often? \_\_\_\_\_

Y N Is fluoride taken in any form? How: Y N — Vitamins Y N — Toothpaste Y N — Drinking Water

Y N Any mouth habits (thumbsucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)

Y N Any injuries to mouth, teeth, head? Date(s) \_\_\_\_\_

Y N Has child ever had jaw joint pain or tenderness?

My child uses a bottle (please check one):  no  daytime  nighttime.

My child uses a sippy cup (please check one):  no  daytime  nighttime.

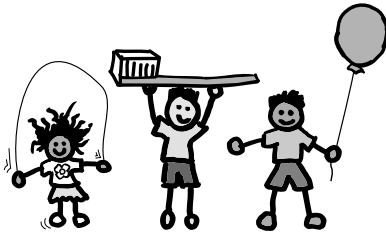
May we request release of your child's medical records?  Yes  No

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: \_\_\_\_\_

I give my consent to needed dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name) \_\_\_\_\_ . I accept responsibility for payment of services rendered.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Parent or Guardian)

Office use only: Doctor's Comments: \_\_\_\_\_



# Great Beginnings

Pediatric & Adolescent Dental Specialists

Board Certified

## It's all about you!

NICKNAME \_\_\_\_\_ AGE \_\_\_\_\_

MY HOBBIES ARE \_\_\_\_\_.

I HAVE A PET \_\_\_\_\_ AND ITS NAME IS \_\_\_\_\_.

MY FAVORITE MOVIE OR TV SHOW IS \_\_\_\_\_.

MY FAVORITE SONG OR GROUP IS \_\_\_\_\_.

MY FAVORITE FOOD IS \_\_\_\_\_.

I GO TO SCHOOL AT \_\_\_\_\_,

AND I'M IN GRADE \_\_\_\_\_.

I LOVE TO LEARN ABOUT \_\_\_\_\_.

I WISH I COULD BE A \_\_\_\_\_.

THE BEST THING THAT EVER HAPPENED TO ME WAS \_\_\_\_\_

\_\_\_\_\_.

MY BEST VACATION WAS \_\_\_\_\_.

SOMETHING UNIQUE ABOUT ME IS \_\_\_\_\_

\_\_\_\_\_.

PLEASE BRING THIS COMPLETED FORM TO YOUR FIRST APPOINTMENT SO WE CAN  
GET TO KNOW YOU!

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