C.A. "BUDDY" BRICE, D.D.S., P.A.
JASON S. RECTOR, D.M.D.

Pediatric Dentistry
1070 Judge Sekul Avenue - Biloxi, Mississippi 39530
(228) 374-8175

GET-ACQUAINTED QUESTIONNAIRE

Full Name of Child ______________________ Date of Birth ______________

Name Child Prefers to be called ______________ Place of Birth ______________

School ______________________ Grade ______________

Please give reason for this visit ______________ Child's Physician ______________

Father ______________ SSN# ______________ DOB ______________

Mother ______________ SSN# ______________ DOB ______________

Parent's Marital Status 1. Married 2. Widowed 3. Separated 4. Divorced 5. Single

Home Address ______________________ City ______________ Zip Code __________

Father's Home Phone ______________ Mother's Home Phone ______________

Father's Work Phone ______________ Ext. ______ Mother's Work Phone ______________ Ext. ______

Cellular ______________ Beeper ______________ Other ______________

Father's Occupation ______________ Employed By ______________

Business Address ______________ How long with present firm? ______________

Mother's Occupation ______________ Employed By ______________

Business Address ______________ How long with present firm? ______________

Do you have dental insurance? ______________ Which company? ______________

- **FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED.**
- **THERE WILL BE A CHARGE FOR BROKEN APPOINTMENTS WITHOUT 24 HOURS NOTICE.**
- **THERE WILL BE A FEE FOR DUPLICATION OF X-RAYS.**

Have we seen others in your family? ______________ Name ______________________

SORG 8708

PLEASE COMPLETE OTHER SIDE

Child's History

This information will provide us with better understanding of your child and help us to render the best dental care possible.

Has your child had any history of heart trouble, rheumatic fever, allergies, diabetes, asthma, kidney or liver involvement, epilepsy, bleeding disorders or brain injury?

Question	Yes	No
If YES, circle the condition	❑	❑
Has your child had any childhood diseases other than measles, mumps, chicken pox, smallpox?	❑	❑
Is your child allergic to any food or medicine?	❑	❑
List ______		
Has your child had any history of sore throats, tonsillitis, or ear aches? (Circle)	❑	❑
Has your child had any history of being under oxygen or general anesthesia?	❑	❑
Has your child experienced any trouble from previous medical or dental care?	❑	❑
Has your child had a cerebral or spastic condition?	❑	❑
Is your child mentally compromised?	❑	❑
Is your child under medical care at present?	❑	❑
If YES, explain: ______		
Is your child taking medicine?	❑	❑
Any history of absent or extra teeth in child? In Family? (Circle)	❑	❑
a. Fluoridated tap water	❑	❑
b. Fluoride solutions applied to the teeth by a dentist	❑	❑
c. Fluoride tablets prescribed by a dentist or physician	❑	❑

Check One: Yes / No

Please give name of your water system ______

Give date of last dental care: ______

Dr.'s Name and Address ______

REMARKS: ______

______

In case of emergency who may we contact other than spouse?

Name: ______ **Phone:** ______ **Relationship to Patient:** ______

Address: ______

Please Sign ______ **Relationship to patient** ______

Date ______