

Dr. Jeffrey S. Harris, D.M.D., P.C.

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EMAIL Smiles4Ever@HarrisDentalArts.com

WEB www.HarrisDentalArts.com



Our goal is to help each of our patients reach and maintain the maximum oral health possible. We achieve this by examination, treatment and education. The commitment we have to each patient is to provide care with the latest state of the art equipment and techniques.

HARRIS DENTAL ARTS

Please fill out these forms completely so that we can better care for your child.

ABOUT YOUR CHILD

Form for 'ABOUT YOUR CHILD' containing fields for Today's date, Name (FIRST, MI, LAST), Child's Nickname, Birthdate, School, Child's Home Phone#, Address, City, State, Zip, Special interests, sports or hobbies, and Does your child need to be pre-medicated before dental treatment? (Yes/No).

GUARDIAN INFORMATION

Form for 'GUARDIAN INFORMATION' containing fields for Who is accompanying the child today? (Name: FIRST, MI, LAST), Relation, Do you have legal custody of this child? (Yes/No), Who may we thank for referring you?, Other family members seen by us?, Previous | Present Dentist, Last Visit Date, Guardian's Marital Status (Single, Widowed, Married, Divorced, Separated), Who will pay this Account?, Signature, If using Credit Card (Name, Card Number, Exp. Date), and another Signature/Exp. Date field.

By signing above, I authorize any unpaid balance on my account to be charged to my credit card above.

EMERGENCY INFORMATION

Form for 'EMERGENCY INFORMATION' containing the question 'In the event of an emergency, is there someone who lives near you that we should contact?' and fields for Name, Relation, Home Phone, Work Phone, Ext#, and Cell Phone.

DENTAL HISTORY

Form for 'DENTAL HISTORY' containing fields for Why did you bring the child to the dentist today?, Last dental visit?, Last X-rays?, Has the child ever had a serious | difficult problem associated with any previous dental work? (No/Yes), Is the child's water fluoridated? (No/Yes), Is the child taking fluoride supplements? (No/Yes), Has the child ever had any pain | tenderness in their jaw joint? (TMJ | TMD)? (No/Yes), Does the child brush their teeth daily? (No/Yes), Does the child floss their teeth daily? (No/Yes), Child's Physician, Date of Last Visit, Physician's Phone #, Is the child currently under the care of a physician? (No/Yes), Please describe the child's current physical health: (Good, Fair, Poor), Please list all drugs that the child is currently taking, and Please list all drugs that the child is allergic to.

PARENT'S INFORMATION

Form for 'PARENT'S INFORMATION' containing fields for Mother's Information (Step mother, Guardian), Name, Work Phone #, Ext#, Home #, Cell#, Employer, SS#, Father's Information (Step father, Guardian), Name, Work Phone #, Ext#, Home #, Cell#, Employer, Who is responsible for making appointments?, Name, Cell#, Work Phone #, Ext#, and Home #.

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MEDICAL HISTORY

Has your child ever had any of the following diseases or medical problems? Circle yes or no.

Y	N	Heart Murmur	Y	N	Asthma	Y	N	Hearing Impairment
Y	N	Cancer Chemotherapy	Y	N	Hepatitis	Y	N	Any Operations
Y	N	Diabetes	Y	N	Tuberculosis (TB)	Y	N	Any stays in a Hospital
Y	N	Rheumatic Fever	Y	N	Congenital Heart Defect	Y	N	Kidney Liver Problems
Y	N	HIV+ AIDS	Y	N	Convulsions Epilepsy	Y	N	Handicaps Disabilities
Y	N	Hemophilia Abnormal Bleeding	Y	N	Abnormal Bleeding	Y	N	Allergies to any drugs

Please list any serious medical condition(s) the child has ever had:

Does your child have any of the following habits? Circle yes or no.

Y	N	Thumb Finger Sucking	Y	N	Nail Biting
Y	N	Lip Sucking Biting	Y	N	Nursing Bottle Habits

Is your child allergic to any of the following:

Y	N	Penicillin	Y	N	Erythromycin	Y	N	Latex
Y	N	Aspirin	Y	N	Codeine	Y	N	Other
Y	N	Tetracycline	Y	N	Dental Anesthetics			

Please list any other drugs the child is allergic to:

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services my child may need.

Signature: _____ Date: _____

OFFICE USE ONLY

I verbally reviewed the medical | dental information above with the parent/guardian named herein.

Initial: _____ Date: _____

Doctor's Comments:

Penicillin	Aspirin	Allergies Medical History	Medicines	Hospitalizations
1. Date	Comments		Signature:	
2. Date	Comments		Signature:	
3. Date	Comments		Signature:	
4. Date	Comments		Signature:	
5. Date	Comments		Signature:	

HARRIS DENTAL ARTS

Please use this form if you need additional room to supply medical information.

Patient Name: _____

Date of Birth: _____

Today's Date: _____

Medications: *(name, dosage, frequency)*

Surgeries: *(date, surgery, area)*

Any other pertinent medical information?
