Dr. Jeffrey S. Harris, D.M.D., P.C.
PHONE 610.388.6789 | FAX 610.388.7042
EMAIL Smiles4Ever@HarrisDentalArts.com
WEB www.HarrisDentalArts.com

HARRIS DENTAL ARTS

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.

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

ABOUT YOUR CHILD

Today's date:

Name: First MI Last

Child's Nickname: ☐ Male ☐ Female

Birthdate: Child's Age:

School: Grade:

Child's Home Phone#: SS#:

Address: Apt | Condo#:

City: State: Zip:

Special interests, sports or hobbies:

Does your child need to be pre-medicated before dental treatment?: ☐ Yes ☐ No

GUARDIAN INFORMATION

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: CVV Code:

Signature: Exp. Date: Billing Zip Code:

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

EMERGENCY INFORMATION

In the event of an emergency, is there someone who lives near you that we should contact?

Name: Relation: Home Phone:

Work Phone: Ext#: Cell Phone:

DENTAL HISTORY

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:

Please list all drugs that the child is allergic to:

PARENT'S INFORMATION

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#:

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

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.

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

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 Medicines Hospitalizations

Medical History

1. Date	Comments	Signature:
2. Date	Comments	Signature:
3. Date	Comments	Signature:
4. Date	Comments	Signature:
5. Date	Comments	Signature:

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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?

_____

_____

_____