Welcome

William D. Titus, DMD, PA
542182 U.S. Highway 1, - Callahan, FL 32011-8109 - 904-879-3786

1. Tell Us About Your Child

Today's Date: _____

Name:_____
(LAST) (FIRST) (M.I.) (Mr./Mrs./Miss/Ms./Dr.)

Child's Nickname:_____ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age:_____

School:_____ Grade:_____

Child's Phone #: _____ SSN: ___-___-_____

Child's Address:_____

City:_____State:_____Zip:_____

Other family members seen in our office: _____

_____

Previous / Present Dentist: _____

Last Visit:_____ Last Exam:_____

2. Who is accompanying the child?

Name:_____

Relation:_____ Legal Guardian? ☐ Yes ☐ No

Work Phone:_____ Ext.:_____

SSN:_____ Birthdate:____/____/_____

Driver License No.:_____ State:_____

Parent's marital status: ☐ Single ☐ Married ☐Divorced ☐ Widowed ☐Separated

3. Parental Information

FATHER

Name:_____

Work #:_____ Ext.:_____ Home #:_____

Employer:_____

SSN:_____-_____-_____ DL#_____

MOTHER

Name:_____

Work #:_____ Ext:_____ Home #:_____

Employer:_____

SSN:_____-_____-_____ DL#_____

Which parent is responsible for making appointments: _____

_____

4. Dental Insurance Info.

PRIMARY DENTAL INSURANCE

Insurance Co. Name:_____

Ins. Co. Address:_____

Ins. Co. Phone:_____

Group # (Plan or Policy#):_____

Insured's Name:_____Relationship:_____

Insured's B'day.:____/____/____ & SSN:____-____-_____

Insured's Employer:_____

SECONDARY DENTAL INSURANCE

Insurance Co. Name:_____

Ins. Co. Address:_____

Ins. Co. Phone:_____

Group # (Plan or Policy#):_____

Insured's Name:_____Relationship:_____

Insured's B'day.:____/____/____ & SSN:____-____-_____

Insured's Employer:_____

5. Why did you bring the child?

Has the child ever had a serious or difficult problem with dental appointments or medical appointments?	☐ Yes	☐ No
Is your child having dental or mouth pain?	☐ Yes	☐ No
Does the child have speech problems?	☐ Yes	☐ No
Is there concern over smile appearance?	☐ Yes	☐ No
Is there concern with breath odor?	☐ Yes	☐ No
Is the child's water fluoridated?	☐ Yes	☐ No
Is the child taking fluoridated supplements?	☐ Yes	☐ No
Does the child brush their teeth daily?	☐ Yes	☐ No
Does the child floss teeth daily?	☐ Yes	☐ No
Has your child reached puberty?	☐ Yes	☐ No
Does the child have any of the following habits:		
Thumb,Finger Sucking, Pacifier	☐ Yes	☐ No
Lip Sucking / Biting	☐ Yes	☐ No
Nail Biting	☐ Yes	☐ No

No child under 18 will be seen in our office without a legal guardian being present for the entire visit. Please note, a child deemed un-accompanied will have their treatment stopped immediately.

X_____Date:_____

Patient Name:_____ Date:_____

MEDICAL HISTORY

1. Have your child been under the care of a medical doctor during the past two years? ..... Yes No

If so, please list doctor, condition, treatment and dates:

DOCTOR'S NAME	CONDITION/TREATMENT	DATE

2. List all medications your child has taken in the last six months:_____

_____

_____

3. Is your child sensitive or allergic to any medication? ..... Yes No
   Circle any meds you are allergic to: PENICILLIN ASPIRIN CODEINE ERYTHROMYCIN CLINDAMYCIN TETRACYCLINE
   OTHERS:_____
4. Are you sensitive or allergic to any metals..... Yes No
5. Females Only: Is your daughter pregnant?..... Yes No
   Is she taking birth control pills?..... Yes No
6. Has a physician ever told you that your child needs to pre-medicate with antibiotics before having dental treatment done
   Due to a heart or medical condition?..... Yes No

Please circle any of the following conditions which your child has been diagnosed with by a physician:

Cardiovascular (Heart / Circulation)

1. Heart murmur
2. Rheumatic fever
3. Mitral valve prolapse
4. Artificial heart valve
5. High blood pressure (hypertension)
6. Low blood pressure
7. Heart disease and / or heart attack
8. Angina pectoris
9. Heart pacemaker
10. Heart surgery

Kidney and Liver

1. Liver disease
2. Kidney trouble
3. Excessive bleeding
4. Hepatitis A Hepatitis B Hepatitis C Other
5. Jaundice
6. G. I. disorder (Chrone's, Diverticulitis, IBS, etc.)

Neurological

1. Parkinson disease
2. Epilepsy or seizures

Miscellaneous

1. Artificial joint
2. Cancer or tumor
3. Leukemia
4. Chemotherapy or radiation therapy
5. Anemia
6. Emphysema
7. Tuberculosis
8. HIV, AIDS or ARC
9. Diabetes Type I Type II
10. Ulcers
11. Asthma
12. Sinus trouble
13. Thyroid disease
14. Arthritis
15. Psychiatric treatment (depression, anxiety, etc.)
16. Hemophilia
17. Venereal disease (syphilis, gonorrhea, herpes)
18. Organ removal or transplant
19. Glaucoma
20. Prostate / Urinary tract problems
21. Tempromandibular Joint Dysfunction (TMJ)
22. Attention deficit disorder / hyperactivity (ADD/ADHD)

To the best of my knowledge, all of the preceding answers to this questionnaire are true and correct. If my child has any changes in their health or medications, I will notify this office at the next appointment without fail.

_____ _____ _____
(SIGNATURE OF PATIENT, PARENT OR GUARDIAN) (DATE) (SIGNATURE OF DENTIST)

Med.Update 1: _____ by:_____ on:___/___/___ Med Update 2: _____ by:_____ on:___/___/___