TAYLOR DENTISTRY

MARK H. TAYLOR, D.D.S., PEDIATRIC SPECIALIST
BRETT H. TAYLOR, D.D.S., COMPREHENSIVE FAMILY DENTIST

14707 California St. Suite #4 Omaha, NE 68154 Phone 402-333-0274

Patient's name _____ Date of Birth_____

Mother's Name_____ Mother's S.S.N._____

Mother's Address _____City/State_____

Zip _____Home phone_____ Work phone_____

Mother's Email _____

Mother's place of employment _____

Mother's dental insurance company_____

Group ID number _____ Date of Birth _____

Father's Name_____ Father's S.S.N._____

Father's Address _____ City/State_____

Zip _____Home phone_____ Work phone_____

Father's Email _____

Father's place of employment _____

Father's dental insurance company _____

Group ID number _____ Date of Birth _____

Person to reach in case of emergency & relationship _____

Authorization and Release

I authorize Mark H. Taylor, D.D.S., to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers.

I authorize payment of my dental benefits, otherwise payable to me, directly to Mark H. Taylor, D.D.S.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

Signature of parent _____

Date_____

TAYLOR DENTISTRY
PEDIATRIC HEALTH HISTORY

Patient Name _____ Parent/Guardian signature _____

Date____/____/____ Birthdate ____/____/____ Nickname_____ Child's Physician _____

Medical History

Yes	No		Yes	No	
❑	❑	AIDS	❑	❑	Is your child under a physician's care? For what?
❑	❑	Allergies			
❑	❑	Anemia	❑	❑	Has your child ever been hospitalized? For what?
❑	❑	Arthritis			
❑	❑	Asthma	❑	❑	Taking any medications? Please list:
❑	❑	ADHD			
❑	❑	Autism			
❑	❑	Bleeding Problem	❑	❑	Allergic to any medications? Please list:
❑	❑	Blood Disease			
❑	❑	Hi/Lo Blood Pressure	❑	❑	Allergic to metals or latex?
❑	❑	Cancer/Tumors	❑	❑	Are your child's immunizations up to date?
❑	❑	Diabetes			
❑	❑	Epilepsy/Seizures			
❑	❑	Eye problems			
❑	❑	Hearing Problem			
❑	❑	Heart Murmur			
❑	❑	Heart Problem			
❑	❑	Hepatitis			
❑	❑	Kidney Disease			
❑	❑	Learning Disability			
❑	❑	Liver Disease			
❑	❑	Lung Disease			
❑	❑	Rheumatic Fever			
❑	❑	Skin Disease			
❑	❑	Thyroid Disease			
❑	❑	Tuberculosis			
❑	❑	Other			

Dental History

Yes	No		Yes	No	
❑	❑	Is this your child's first visit to the dentist?	❑	❑	Does your child receive fluoride in any of the following forms? If yes, check below. ❑ Vitamins ❑ Toothpaste ❑ Tablets/Drops ❑ Rinse/Gel
❑	❑	Does your child have a thumb, finger, or pacifier sucking habit?	❑	❑	Any recent injury to the teeth? Please explain:
❑	❑	Is your child a mouth breather?			
❑	❑	Any previous negative dental experiences?			What is your main concern regarding your child's oral health?
❑	❑	Does your child brux or grind the teeth?			
❑	❑	Is your water fluoridated?			
❑	❑	Does your child brush and floss daily? Brushes _____ times per day.			
❑	❑	Does an adult assist or supervise brushing and flossing?			
❑	❑	Does your child have frequent between meal snacks? Check type of snack below. ❑ Sweets ❑ Pop ❑ Crackers ❑ Fruit/Vegetable			