CONNIE BRUCE-GILLIAM, D.D.S.

Pediatric Dentistry
Infants, Children and the Handicapped

2 Office Park Drive
Jacksonville, NC 28546
(910) 577-5077

THE FOLLOWING INFORMATION AND HISTORY ARE NECESSARY FOR ADEQUATE TREATMENT AND UNDERSTANDING OF YOUR CHILD. THANK YOU FOR COMPLETING IT IN FULL.

Patient's Name _____ Nickname _____ Age _____
Sex _____ Race _____ Date of Birth _____ Place of Birth _____ Social Security # _____
Patient's Address _____ Home Phone _____
Street City State Zip
Cell Phone _____ E-mail Address _____
Father's Name _____ Social Security # _____
Date of Birth
His Address _____ Phone _____
Street City State Zip
Where Employed _____ Phone _____
Occupation
Father's Dental Insurance _____
Company Address Policy #
Father's Major Medical Insurance _____
Company Address Policy #
Mother's Name _____ Social Security # _____
Date of Birth
Her Address _____ Phone _____
Street City State Zip
Where Employed _____ Phone _____
Occupation
Mother's Dental Insurance _____
Company Address Policy #
Mother's Major Medical Insurance _____
Company Address Policy #
With whom does patient live? _____
Other children in family - names and ages _____
Child's Physician _____ Family Dentist _____
Whom may we thank for referring you to our office ❑ Doctor ❑ Parent ❑ Patient _____
Name of Person Referring Patient
_____
Address - Street of RFD Town State Zip

HEALTH HISTORY

	Yes	No
Is your child in good health?	____	____
Does your child have regular medical exams?	____	____
Is your child up to date with immunizations?	____	____
Is your child presently taking medicine?	____	____
If so, what? _____		
Has your child experienced any unfavorable reaction to medicine?	____	____
If so, what? _____		
Is your child presently undergoing medical treatment?	____	____
If so, what? _____		
Has your child been hospitalized since birth?	____	____
Date _____ Reason _____		
List any infectious diseases _____		

Check any of the following that may pertain to your child

_____ Heart Condition	_____ Tuberculosis
_____ Lung Problem	_____ Asthma
_____ Brain Injury	_____ Allergies
_____ Liver Problem	_____ Downs Syndrome
_____ Kidney Problem	_____ Retardation
_____ Epilepsy	_____ Mental Disorder
_____ Diabetes	_____ Emotional Disorder
_____ Cerebral Palsy	_____ Autism
_____ Bleeding Disorder	_____ Speech Disorder
_____ Sickle Cell Anemia	_____ Hearing Disorder
_____ Hepatitis	_____ Vision Disorder
_____ HIV or AIDS*	_____ Congenital Syndrome
_____ Cystic Fibrosis	_____ ADD or ADHD
_____ Other _____	

What is your water source? Private well? ❑ Public System? ❑ Name of system: _____

	Yes	No
Is this is your child's first dental visit?	____	____
If not, date of last dental care _____		
Has your child had an unfavorable experience in a dental office?	____	____
Does your child have a toothache?	____	____
Purpose of this appointment _____		

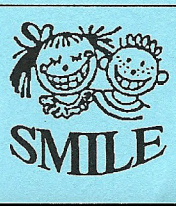
	Yes	No
Is your child a fingersucker?	____	____
Does your child use a pacifier?	____	____
Was your child bottle-fed?	____	____
Age discontinued _____		
Was your child breast-fed?	____	____
Age discontinued _____		

Thank you for your help. If there is any information that you think might be of value to us in treating your child, please feel free to comment:

_____

_____

I agree to diagnostic procedures and dental treatments as found necessary and desirable by Connie Bruce-Gilliam, D.D.S. for the patient named above. I will accept responsibility for this account should named responsible party fail or insurance benefits be denied.



Date _____ _____
Signature of person legally responsible
_____ Dental Assistant reviewing history

BROKEN APPOINTMENT AGREEMENT

In the event that you must miss a scheduled appointment, a verbal or written notice must be submitted at least 24 hours prior to the scheduled appointment. A message on the answering service is sufficient. If an emergency arises the day of the appointment, the office must be notified as soon as possible so that another patient may be scheduled. If you do not show for a scheduled appointment and the office receives no notification, there will be a **$10.00-$25.00 Broken Appointment Fee**. Gilliam Dentistry reserves the right to restrict appointment to individuals that repeatedly cancel appointments.

My signature below indicates that I have read and understand the Broken Appointment policy set forth by Drs. Maxwell and Connie Gilliam.

Name_____ Date_____