PAMELA R.SINGLETARY, D.D.S.
TEXAS TOOTH FAIRIES PEDIATRIC DENTISTRY

3401 El SALIDO PKWY, CEDAR PARK TX 78613

Child's Name _____ Preferred Name _____ Age _____ DOB _____Sex: F/M

Child's Physician _____ Phone #_____

Person accompanying child to appointment: _____

Preferred method of contact for appointment reminder notifications: Text Email Phone Call

Has your home address/phone number/email changed? YES or NO (If YES, please fill out the following)

Address/City/Zip: _____

Home Phone : _____ Work: _____Cell# _____

Email Address: _____

Has your dental insurance changed? YES or NO (If YES, please fill out the following and/or allow us to see your card)

Insured Name _____ SSN/ID _____

DOB _____ Relationship to Child _____

Place of Employment _____ Occupation _____

Work Phone# _____

Name of Dental Carrier _____ Group# _____

Mailing Address for Dental Claims _____

Phone# _____

Please circle <u>YES</u> or <u>NO</u> to the following:

Abnormal Bleeding or Bruising	Yes No	Cleft Lip or Palate	Yes No	Liver Disease	Yes No
ADD/ADHD	Yes No	Convulsions or Seizures	Yes No	Mumps, Measles or Chickenpox	Yes No
AIDS Virus	Yes No	Date of last Seizure _____		Nervous or Emotional Disorders	Yes No
ALLERGIES:		Diabetes	Yes No	Problems w/ Anesthesia	Yes No
Food_____	Yes No	Downs Syndrome	Yes No	Prolonged Bleeding/Transfusions	Yes No
Medication(s)_____	Yes No	Ear, Eye, Nose or Throat Trouble	Yes No	Rheumatic Heart Disease/Fever	Yes No
Latex	Yes No	Eating Disorders	Yes No	Scarlet Fever or High Fever	Yes No
Seasonal	Yes No	Frequent Diarrhea or Vomiting	Yes No	Sensory Integration Issues	Yes No
Asthma	Yes No	Hearing/Vision Impairment	Yes No	Sinus Problems or Drainage	Yes No
Autism Spectrum	Yes No	Heart Trouble or Heart Murmur	Yes No	Steroid Therapy or Chemotherapy	Yes No
Birth Defects	Yes No	Herpes Virus or Shingles	Yes No	Stomach Ulcers	Yes No
Blood Diseases or Anemia	Yes No	High or Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Cancer, Tumors, Growths or Cysts	Yes No	Jaundice or Hepatitis	Yes No	Tuberculosis or TB Exposure	Yes No
Cerebral Palsy	Yes No	Kidney Disease	Yes No	Other _____	

<u>CURRENT MEDICATIONS:</u>

Name/Strength (mg)	How Often?	Reason Taken
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child had any dental trauma since their last dental visit? Yes or No

Did they see a dentist for this trauma? Yes or No

If so who? _____ When? _____

How often does your child brush? _____ Electric toothbrush? Yes or No

How often does your child floss? Daily Sometimes Never

Parent's Signature: _____ Date: _____