1268 Ocean Springs Rd.
Ocean Springs, Mississippi 39564
(228) 215-3100

Pediatric Dental Specialists
C.A."Buddy" Brice D.D.S.,P.A.
Austin J. McMurphy, D.M.D.M.S.
www.BipposKids.com

1070 Judge Sekul Ave.
Biloxi, Mississippi 39530
(228) 374-8175

New Patient Forms

Full Name of Child _____ Date of Birth _____

Name Child Prefers to be called _____ Place of Birth _____

School _____ Grade _____

Please give reason for this visit _____ Child's Physician _____

Father _____ SSN# _____ DOB _____

Mother _____ SSN# _____ DOB _____

Parent's Marital Status 1. Married 2. Widowed 3. Separated 4. Divorced 5. Single

Home Address _____ City _____ Zip Code _____

Father's Home Phone _____ Mother's Home Phone _____

Father's Work Phone _____ Ext. Mother's Work Phone _____ Ext.

Father's Cell _____ Mother's Cell _____ Email _____

Father's Occupation _____ Employed By _____

Business Address _____ How long with present firm? _____

Mother's Occupation _____ Employed By _____

Business Address _____ How long with present firm? _____

Do you have dental insurance? _____ Which company? _____

- **FEES ARE PAYABLE AT THE TIME SERVICES ARE RENDERED.**
- **THERE WILL BE A CHARGE FOR BROKEN APPOINTMENTS WITHOUT 24 HOURS NOTICE.**
- **THERE WILL BE A FEE FOR DUPLICATION OF X-RAYS.**

Have we seen others in your family? _____ Name _____

SORG 8708

PLEASE COMPLETE OTHER SIDE

Child's History

This information will provide us with better understanding of your child and help us to render the best dental care possible.

		Check One: Yes	No
1.)	Has your child had any history of heart trouble, rheumatic fever, allergies, diabetes, asthma, kidney or liver involvement, epilepsy, bleeding disorders or brain injury? **If YES, circle the condition above.**	❑	❑
2.)	Is your child under medical care at present? If YES, explain: _____	❑	❑
3.)	Is your child taking medicine? List: _____	❑	❑
4.)	Has your child had any childhood diseases other than measles, mumps, chicken pox, smallpox?	❑	❑
5.)	Is your child allergic to any food or medicine? List: _____	❑	❑
6.)	Has your child had any history of sore throats, tonsillitis, or ear aches? (Circle)	❑	❑
7.)	Has your child had any history of being under oxygen or general anesthesia?	❑	❑
8.)	Has your child experienced any trouble from previous medical or dental care?	❑	❑
9.)	Has your child had a cerebral or spastic condition?	❑	❑
10.)	Does your child have an Intellectual Disability?	❑	❑
11.)	Any history of absent or extra teeth in child? In Family? (Circle)	❑	❑
12.)	Do you have any of the following? (Circle)	❑	❑
	a. Fluoridated tap water	❑	❑
	b. Fluoride solutions applied to the teeth by a dentist	❑	❑
	c. Fluoride supplements prescribed by a dentist or physician	❑	❑

Please give name of your water system _____

Give date of last dental care:_____

Dr.'s Name and Address _____

REMARKS: _____

_____

In case of emergency who may we contact other than spouse?

Name:_____ **Phone:**_____ **Relationship to Patient:** _____

Address:_____

Please Sign_____ **Relationship to Patient:** _____

Date_____