JOHN J. FLOWERS, JR., D.M.D.
KRISTEN F. CROWDER, D.M.D.
CHILDREN'S DENTISTRY AND ORTHODONTICS
2431 WEST MAIN STREET
DOTHAN, ALABAMA 36301
(334) 793-9635

PATIENT INFORMATION FORM

CHILD'S NAME _____ AGE _____ SEX _____

CHILD'S NICKNAME _____ BIRTHDAY _____ SOCIAL SECURITY # _____

ADDRESS _____

HOME PHONE NO. _____

PARENT OR GUARDIAN _____ RELATIONSHIP TO PATIENT _____

DATE OF BIRTH _____ SOCIAL SECURITY _____

DENTAL INSURANCE: YES_____ NO_____ INSURANCE COMPANY _____

E-MAIL ADDRESS _____

TELEPHONE NO. (CELL) _____

(WORK) _____ EMPLOYER _____

Who should we thank for referring you? _____

PAST MEDICAL HISTORY

Is your child seeing a doctor (Physician/MD/Osteopath/Chiropractor) for any reason? ☐ No ☐ Yes If so, please explain _____

_____

Has your child ever been in the hospital? ☐ No ☐ Yes If so, please explain _____

_____

Has your child ever had an operation? ☐ No ☐ Yes If so, please explain _____

_____

Has your child ever had a serious illness or injury? ☐ No ☐ Yes If so, please explain _____

_____

Has your child ever had a blood transfusion? ☐ No ☐ Yes If so, when _____

_____

Is your child allergic to any medicines, dust, pollens, etc.? ☐ No ☐ Yes If so, please explain _____

_____

Is your child taking any medication? ☐ No ☐ Yes If so, please explain _____

_____

CONTINUED ON BACK

Has your child had any of the following illnesses and/or conditions?

Heart Disease	☐ No	☐ Yes	
Rheumatic Fever	☐ No	☐ Yes	
Heart Murmur	☐ No	☐ Yes	
High Blood Pressure	☐ No	☐ Yes	
Respiratory Disease	☐ No	☐ Yes	
Asthma	☐ No	☐ Yes	
Tuberculosis	☐ No	☐ Yes	
Wheezing	☐ No	☐ Yes	
Hepatitis	☐ No	☐ Yes	
Jaundice	☐ No	☐ Yes	
Diabetes	☐ No	☐ Yes	
Thyroid Problems	☐ No	☐ Yes	
Kidney Infections	☐ No	☐ Yes	
Kidney Disease	☐ No	☐ Yes	
HIV	☐ No	☐ Yes	
Sickle Cell Disease	☐ No	☐ Yes	
Anemia	☐ No	☐ Yes	
Bleeding Disorder	☐ No	☐ Yes	
Leukemia	☐ No	☐ Yes	
Seizures	☐ No	☐ Yes	
Allergies	☐ No	☐ Yes	
Handicaps	☐ No	☐ Yes	
Birth Defects	☐ No	☐ Yes	
Syndromes (Down's, etc.)	☐ No	☐ Yes	
Mental Retardation	☐ No	☐ Yes	
Learning Disability	☐ No	☐ Yes	
Autism	☐ No	☐ Yes	
Speech or pronunciation problems	☐ No	☐ Yes	
Hearing Impairment	☐ No	☐ Yes	

Who is your child's medical doctor?

Name _____

Address _____

Because this patient is a minor it is necessary for us to have consent of the child's parent or legal guardian prior to rendering dental services. Therefore, your signature below authorizes Dr. Flowers or Dr. Crowder and their staff to collect the necessary diagnostic and study information, and to provide whatever dental treatment, medicines and therapy that may be indicated for this child in Dr. Flowers' or Dr. Crowder's best judgement.

Signature _____ Date _____

Relation _____

This consent shall remain in effect until cancelled by either party.

All treatment plans and services rendered will be discussed with the parent prior to beginning treatment.

Payment due when services are rendered.