Frank L. Conaway Jr, DMD, PC
292 Hancock Square
Bay St. Louis, MS 39520 (228)467-4670

Child's Name________________________________ Birthdate_________________ SS#_____________

Address____

School____ Grade______________

Referred By____

Mother's Name______________________________ Birthdate____________ SS#__________________

Residence____

Home Phone_________________ Work Phone_____________________ Cell Phone________________

Employer____Occupation_____________ How Long?____

Father's Name_______________________________ Birthdate____________ SS#__________________

Residence____

Home Phone_________________ Work Phone_____________________ Cell Phone________________

Employer____ Occupation_____________ How Long?_____

Person Responsible For Account___________________________________ Relation_________________

Mailing Address____

How Long At This Address____________ E-mail ____

Dental Insurance Co.____ Phone # _____________________

Group Number _______________________ Member ID Number ________________________________

Insured's Name____ Relation________________

Reason For Today's Visit *Exam* *Emergency* *Consultation* Is Child In Pain?___________

Please Indicate The Following Problems:

Discomfort, clicking/popping in jaw	Y N	Lost/broken fillings	Y N
Stained teeth	Y N	Red, swollen or bleeding gums	Y N
Teeth grinding/clenching	Y N	Locking jaw	Y N
Sensitive teeth or gums	Y N	Bad breath	Y N
Blisters/sores in or around mouth	Y N	Broken/chipped teeth	Y N

Previous Dentist____ Last Dental Exam_________________

How Often Does Child Brush________ How Often Is Floss Used________ Is Fluoride Used_________

Over Please

In The Event Of An Emergency Whom Should We Contact___________________________________

Complete Address____

Home Phone________________________ Cell Phone______________________ Relation________

Child's Health Is *Excellent* *Good* *Fair* *Poor* Is Child Under A Physician's Care___________

Physician's Name_____________________________________ Phone Number_____________________

Please List Any Medications Child Is Currently Taking____

____

Does Child Have Or Ever Had Any Of The Following (*Please Circle Each One "Y" Yes or "N" No)*:

Heart Murmur	Y N	Tonsillitis	Y N	High/Low Blood Pressure	Y N
Rheumatic Fever	Y N	Respiratory Problems	Y N	HIV/AIDS	Y N
Artificial Heart Valve	Y N	Asthma	Y N	Hepatitis	Y N
Congenital Heart Defect	Y N	Blood Transfusion	Y N	Artificial Bones/Joints	Y N
Scarlet Fever	Y N	Leukemia	Y N	Tuberculosis	Y N
Surgeries/Operations	Y N	Diabetes/Hypoglycemia	Y N	Liver/Kidney Problems	Y N
Cancer/Tumors	Y N	Hemophilia	Y N	Psychiatric Problems	Y N
Chemotherapy	Y N	Abnormal Bleeding	Y N	Hyper Active/ADD	Y N
Jaw Problems/TMJ	Y N	Cleft Lip/Palate	Y N	Epilepsy/Seizures	Y N
Hearing Problems	Y N	Birth Defects	Y N	Cerebral Palsy	Y N

Does Child Require An Antibiotic Before Dental Treatment Due To A Medical Condition? Y N

Is Child Allergic To Any Medication, Food, Latex Or Other?____

Is There Any Other Condition Concerning Your Child's Health?____

Does Child Do Any Of The Following: *Thumb/Finger Sucking* *Tongue/Thrusting/Sucking* *Heavy Snoring* *Mouth Breathing* *Lip Sucking/Biting*

Our dental office sends appointment reminders, info about treatment, payment, insurance, and other communications. Please tell us how you would like us to communicate with you. **Check all that apply.**

- Call me
- Text me
- Email me

By signing below, you give consent to our office to contact you using the method(s) you have indicated. (Please note that if you choose to be contacted electronically for upcoming appointments, you will receive multiple reminders).

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between Dr. Conaway and the patient.
- By signing below you authorize Dr. Conaway to perform any necessary services needed during diagnosis and treatment.
- Please be advised due to our insurance liability, all patient records must remain with the office. However, for a nominal fee, copies of records may be forwarded upon request.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature (*Parent's if patient is a minor)*____ Date_________