

# Dr. Al Pelphrey

300 North Mayo Trail, Suite 1 - Pikeville, KY 41501 (606) 437-1461 or (606) 437-0631

## HEALTH QUESTIONNAIRE

General Information \_\_\_\_\_ Date \_\_\_\_\_

Mother (or Guardian) \_\_\_\_\_

Father (or Guardian) \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

City, Zip \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Social Security No. \_\_\_\_\_

Social Security No. \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

City, Zip \_\_\_\_\_

City, Zip \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Person and phone number (other than parent) to contact in case of emergency: \_\_\_\_\_

Who may we thank for referring you to us? \_\_\_\_\_

**PLEASE COMPLETE THE FOLLOWING INFORMATION. If you want this office to work with your insurance carrier:**  
First Dental Insurance Company Name \_\_\_\_\_ Which parent? \_\_\_\_\_  
Second Dental Insurance Company Name \_\_\_\_\_ Which parent? \_\_\_\_\_  
I hereby authorize the release of medical information to my insurance company that may be pertinent to my case. I further authorize direct payment to Dr. Al Pelphrey D.M.D., from the above-listed companies (if any) and any unpaid balance will be paid by me.  
\_\_\_\_\_  
Parent Signature

**CHILD'S HISTORY (These questions are of great value in aiding us to better understanding of your child.)**  
Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
Male Female Child's Address \_\_\_\_\_  
Names and Ages of Brothers and Sisters \_\_\_\_\_ Location \_\_\_\_\_  
Child's Physician or Pediatrician \_\_\_\_\_

<b>DENTAL HISTORY</b>	<b>NO</b>	<b>YES</b>
1. Is this your child's first visit to the dentist? .....	_____	_____ If no, date of last checkup: _____
2. Has your child had a toothache recently? .....	_____	_____ If yes, list _____
3. Has your child fallen and chipped or bumped any of his teeth? .....	_____	_____ If yes, list _____
4. Has your child had any unfavorable experience in the dental office? .....	_____	_____ If yes, explain _____
5. Has your child a history of thumbsucking, lip or nail biting? .....	_____	_____ If yes, how often? _____
6. Do you brush your child's teeth? .....	_____	_____ If yes, how often? _____
7. Does your child receive a fluoride supplement? .....	_____	_____ If yes, what kind? _____
8. Is your child still bottle fed or do they use a sip cup often? .....	_____	_____ If yes, describe _____
9. Do you feel your child will be a cooperative dental patient? .....	_____	_____ If no, why not? _____
10. Has your child ever had: popping, clicking, pain in the jaw, unable to open or close the jaw? .....	_____	_____ If yes, describe _____

**MEDICAL HISTORY**

1. Do you consider your child to be (for his age): Check one: Advanced \_\_\_\_\_ Progressing Normally \_\_\_\_\_ A Slow Learner \_\_\_\_\_

2. What type of water supply do you have? City/County \_\_\_\_\_ or well \_\_\_\_\_

3. Has your child ever experienced any of the following? (Underline if yes)  
Seizures, Heart Disease or Murmurs, Bleeding Disorders, Kidney or Liver Disease, Hepatitis, Bronchitis, Asthma, Blood Transfusion, Rheumatic Fever, Scarlet Fever, Cerebral Palsy, Diabetes, Stomach Disease, Recurrent Headaches, Birth Defects, Endocrine Disease, ...  
Other Medical Problems Not Listed: \_\_\_\_\_

4. Allergies .....

5. Is your child taking any medication at this time .....

6. Is your child taking any Vitamins at this time? .....

7. Has your child had any unfavorable reaction or allergy to medication, such as penicillin, aspirin or local anesthetic? .....

8. Has your child ever been hospitalized? .....

9. Has your child had a physical exam within the last year? .....

### CONSENT:

Your child is a minor. It, therefore, is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary dental service can be started. Authorization is also necessary to release medical information to my physician if needed. Authorization is hereby granted as such.