



Bryan Cobb, DDS, MS

Diplomate, American Board of Pediatric Dentistry

Pediatric Dentistry

2600 A Oakcrest Avenue, Greensboro, North Carolina 27408
(336) 288-9445 • (336) 288-9491 fax

www.bryancobbdds.com

DATE _____

GENERAL INFORMATION:

Father's Name _____ S.S.# _____ DOB: _____
 First Middle Last

Home Address _____ City _____ State _____ Zip _____

How long at this address _____ Home Phone _____ Marital Status _____

Previous Address(if less than 3 yrs.) _____

Occupation _____ Employed by _____ How Long _____

Business Address _____ City _____ State _____ Zip _____ Phone _____

Mother's Name _____ S.S.# _____ DOB: _____
 First Middle Last

Home Address _____ City _____ State _____ Zip _____

How long at this address _____ Home Phone _____ Marital Status _____

Previous Address(if less than 3 yrs.) _____

Occupation _____ Employed by _____ How Long _____

Business Address _____ City _____ State _____ Zip _____ Phone _____

Email _____

Person responsible for account _____ Relationship to child _____

Address _____ City _____ State _____ Zip _____ Phone _____

Previous Address(if less than 3 yrs.) _____

Do you have dental insurance? Yes _____ No _____

If so, name of Insurance Company _____ Policy _____

Name of nearest relative not living with you _____

Address _____ City _____ State _____ Zip _____ Phone _____

CHILD'S HISTORY:

Child's Name _____ Nickname _____ Sex _____ SS#: _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Age _____ Weight _____ School _____

Names and ages of brothers and sisters _____

Child's Physician or Pediatrician _____

Family Dentist _____

Whom may we thank for referring you? _____

IT IS IMPORTANT THAT ALL ITEMS BE COMPLETED



Bryan Cobb, DDS, MS

Diplomate, American Board of Pediatric Dentistry

Pediatric Dentistry

2600 A Oakcrest Avenue, Greensboro, North Carolina 27408

(336) 288-9445 • (336) 288-9491 FAX

www.bryancobbdds.com

CHILD'S NAME _____

MEDICAL HISTORY:

Has your child experienced any of the following?

	YES	NO		YES	NO
Allergies	_____	_____	Heart Disorder	_____	_____
Anemia	_____	_____	Hepatitis (type A or B)	_____	_____
Asthma or Hay Fever	_____	_____	Jaundice	_____	_____
Bleeding Disorders	_____	_____	Kidney or Liver Disease	_____	_____
Bronchitis	_____	_____	Lung Problems	_____	_____
Cerebral Palsy	_____	_____	Mental Disorder	_____	_____
Diabetes	_____	_____	Nervous Disorder	_____	_____
Epilepsy	_____	_____	Rheumatic Fever	_____	_____
Fainting	_____	_____	Seizures	_____	_____
Hearing Disorder	_____	_____	Speech Disorder	_____	_____
Other physical or mental disorders?	_____	_____	HIV (AIDS)	_____	_____

Has any immediate family member had any of the above?

Please describe _____

Is child under care of a physician now? _____ Reason _____

Has child ever been hospitalized? _____ Reason _____

LIST any drug or medicine allergies such as penicillin, aspirin or novocain _____

LIST drugs or medicines presently being taken _____

DENTAL HISTORY:

Do you want complete dental treatment for your child? Yes _____ No _____

What is your main concern about your child's dental health? _____

Has your child ever complained about a dental problem, or had any unhappy dental experiences? Yes _____ No _____ Please explain _____

Is this your child's first visit to the dentist? Yes _____ No _____

Date of last dental visit _____ For what service _____

Were any x-rays taken? Yes _____ No _____

How do you expect your child to behave in our office? _____

YES	NO	
_____	_____	Is your child having a dental problem right now? _____
_____	_____	Has child had any unhappy dental experiences?
_____	_____	Any injuries to mouth, teeth, or head?
_____	_____	Any mouth habits (thumbsucking, nail biting, mouth breather, nursing bottle habits, pacifier, etc.)?
_____	_____	Any unusual speech habits?
_____	_____	Orthodontic appliances worn now or ever?
_____	_____	Does your child brush his/her teeth daily?
_____	_____	Do you assist child with tooth brushing?
_____	_____	Is dental floss used?
_____	_____	Is fluoride taken in any form? How _____

May we request release of your child's medical records? Yes _____ No _____

Thank you for your help. If there is any information that you feel might be of value to us in the treatment of your child, please add it here: _____