



**West Tenn  
Pediatric Dental**  
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206 Murray Guard Drive, Jackson, TN 38305  
731-664-0080/800-237-7011

**GENERAL INFORMATION**

Child's Name \_\_\_\_\_ Name Child goes by \_\_\_\_\_ Sex \_\_\_\_\_ Race \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Child's SS# \_\_\_\_\_ Place of Birth \_\_\_\_\_  
Child's Physician \_\_\_\_\_ Family Dentist \_\_\_\_\_  
Father's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
His Address \_\_\_\_\_ Phone No. \_\_\_\_\_  
Employed by \_\_\_\_\_ Phone No. \_\_\_\_\_  
Mother's Name \_\_\_\_\_ Social Security No. \_\_\_\_\_  
Her Address \_\_\_\_\_ Phone No. \_\_\_\_\_  
Employed by \_\_\_\_\_ Phone No. \_\_\_\_\_  
Who does the child live with? \_\_\_\_\_  
Name and ages of brothers and sisters \_\_\_\_\_  
Dental Insurance \_\_\_\_ yes \_\_\_\_ no Company \_\_\_\_\_ No. \_\_\_\_\_  
Who referred you to us, so we may thank them? \_\_\_\_\_  
Please give us a number you can be reached during the day, so we may confirm appointments. \_\_\_\_\_

**CHILD'S HEALTH HISTORY**

Is your child in good health? \_\_\_\_ yes \_\_\_\_ no  
Date of your child's last medical exam \_\_\_\_\_  
Is your child up to date with immunizations? \_\_\_\_ yes \_\_\_\_ no  
Check any of the following that may pertain to your child:  
\_\_\_\_\_ Heart Condition \_\_\_\_\_ Rheumatic Fever \_\_\_\_\_ Mental Disorder  
\_\_\_\_\_ Liver Disorder \_\_\_\_\_ Asthma \_\_\_\_\_ Nervous Disorder  
\_\_\_\_\_ Kidney Disorder \_\_\_\_\_ Sickle Cell Anemia \_\_\_\_\_ Bleeding Disorder  
\_\_\_\_\_ Lung Problems \_\_\_\_\_ Diabetes \_\_\_\_\_ Speech Disorder  
\_\_\_\_\_ Brain Damage \_\_\_\_\_ Downs Syndrome \_\_\_\_\_ Hearing Disorder  
\_\_\_\_\_ Epilepsy \_\_\_\_\_ Cerebral Palsy \_\_\_\_\_ Vision Disorder  
\_\_\_\_\_ Tuberculosis \_\_\_\_\_ Autism \_\_\_\_\_ Allergies  
\_\_\_\_\_ Hepatitis \_\_\_\_\_ Emotional Disorder \_\_\_\_\_ AIDS  
\_\_\_\_\_ Other  
Is this your child's first trip to the dentist? \_\_\_\_ yes \_\_\_\_ no  
Does your child suck his thumb or finger? \_\_\_\_ yes \_\_\_\_ no  
Does your child use a pacifier? \_\_\_\_ yes \_\_\_\_ no  
At what age was your child weaned from a bottle? \_\_\_\_\_  
Does your child have a tooth that hurts now? \_\_\_\_ yes \_\_\_\_ no  
Has your child ever been in the hospital? \_\_\_\_ yes \_\_\_\_ no  
Is your child allergic to ANY medications? \_\_\_\_ yes \_\_\_\_ no If yes please list \_\_\_\_\_  
Date of child's last dental visit \_\_\_\_\_  
Are you using well water? \_\_\_\_ yes \_\_\_\_ no  
Parent that brings the child to our office is legally responsible to us for payment of the account.

\_\_\_\_\_  
Signature of person responsible for account

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of person completing form

Parent or Guardian Consent: *I hereby give permission to West Tennessee Pediatric Dental Group to provide routine dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, topical anesthetic, voice control, intermittent radiographs, local anesthetics (injections), nitrous oxide, etc.*

Signed \_\_\_\_\_