W. Emory Linder, Jr., D.D.S., P.A.
A. Scott Linder, D.M.D.
1060 Gaines School Road Suite B-1
Athens, GA 30605

Child's Biographical & Social History

Child's full name_____Date_____
Child's nickname_____ Sex_____
Birth-date_____ Birthplace_____
Brothers/sisters_____
Hobbies_____ Pets_____
Grade/school_____
Father's name_____ Father's phone #_____
Father's address_____
_____
Mother's name_____ Mother's phone #_____
Mother's address_____
_____
Do parents live together? **Yes / No**
(if no, with whom does the child live?)_____
Father's occupation/employer_____
Employer's address_____
_____ phone #_____
Mother's occupation/employer_____
Employer's address_____
_____ phone #_____
Emergency contact person/phone #_____
Dental Insurance **Yes / No**

Child's Dental & Medical History

Child's first visit to the dentist? **Yes / No** Child on a bottle? **Yes / No**
Child drink fluoridated water? **Yes / No / don't know**
Child taking fluoride tablets/drops? **Yes / No**
How often are child's teeth brushed?_____
By whom?_____
What type of toothpaste does your child use?_____
Does child suck his/her thumb / finger / lip ?
Has child had any problems with previous dental treatment? **Yes / No**
(If yes what was the problem?)_____
Does child have a dental condition about which you are concerned? **Yes / No**
(If yes, what is the condition?)_____

Indicate whether child has or previously had any of the following conditions:

Yes / No Adrenal disorders
Yes / No Lung disease
Yes / No Eye disorders
Yes / No Asthma
Yes / No Muscle disorder
Yes / No Heart condition
Yes / No Blood disease
Yes / No Prolonged illness
Yes / No Hepatitis
Yes / No Brain disorder
Yes / No Skin disease
Yes / No Hyperactivity
Yes / No Diabetes
Yes / No Stomach problem
Yes / No Liver disease

Yes / No Ear disorders
Yes / No Anemia
Yes / No Intellectual Disabilities
Yes / No Fainting
Yes / No Bleeding tendency
Yes / No Nose/throat disorder
Yes / No Hemophilia
Yes / No Bone disorder
Yes / No Rheumatic fever
Yes / No High Blood Pressure
Yes / No Convulsions
Yes / No Speech problem
Yes / No Jaundice
Yes / No Epilepsy
Yes / No Tumors

Is child taking any medication? **Yes / No**
(If yes, please list.)_____
_____
Does child have any food/medicine allergies? **Yes / No**
(If yes, please list.)_____
_____
Has your child ever been hospitalized? **Yes / No**
(If yes, please explain.)_____
_____
Child's physician:_____ Phone #_____
Physician's address:_____
_____

I acknowledge that the above information is correct and hereby authorize a dental examination for my child, including necessary radiographs (x-rays) and acceptable methods to accomplish these services.

Parent/guardian's signature_____

Date_____