



Dr. Natalie Harrison, D.D. S
Pediatric Dentistry
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Tell us about your child

Child's Name _____
 Nickname _____ Ma
 Child's Birthdate ____/____/____ Age _____
 Child's Home # (_____) _____
 Child's Home Address _____
 _____ Zip Code _____
 Siblings that we treat _____
 Who may we thank for referring you to our office?

Mother's Information

Name _____
 Birthdate ____/____/____
 Marital Status _____
 Address _____
 Employer _____
 Occupation _____
 Work # _____
 Home # _____
 *Cellular Phone # _____
 SS # (optional) _____
 Email address _____

Father's Information

Name _____
 Birthdate ____/____/____
 Marital Status _____
 Address _____
 Employer _____
 Occupation _____
 Work # _____
 Home # _____
 *Cellular Phone # _____
 SS # (optional) _____
 Email address _____

Primary Dental Insurance

If you would like us to fill out your insurance claim please fill out below.

Insurance Co. Name and Address _____

 Insurance Co. Phone # (_____) _____
 Group # (Plan, Local, or Policy #) _____
 Policy Owner's Name _____
 Relationship to Patient _____
 Policy Owner's Birthdate _____
 Social Security # _____
 Policy Owner's Employer _____
 Insurance ID # _____

Dental History

Is this your child's first visit to the dentist? _____
 If not, how long since the last visit to the dentist? _____
 Previous Dentist who serviced your child? _____

 Have there been any injuries to the teeth, face or mouth? _____
 If yes please explain _____
 Why did you bring the child to the dentist today? _____

 Does the child have any of the following habits?
Y N Lip Sucking/Biting **Y N** Nail Biting
Y N Nursing/Bottle Habits **Y N** Thumb/Finger Sucking
 Has the child ever had a serious or difficult problem associated
 with previous dental work? Yes No
 If yes please explain _____
 Does the child brush his/her teeth daily? ____
 Floss his/her teeth daily? _____
 Has your child had an orthodontic evaluation? _____

Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding

Y N Handicapped/Disabilities

Y N Allergies to any Drugs

Y N Hearing Impairment

Y N Any Hospital Stays if yes, please explain _____

Y N Any Operations if yes, please explain _____

Y N Asthma

Y N Hepatitis

Y N Cancer

Y N HIV/AIDS

Y N Congenital Birth Defects

Y N Kidney/Liver Conditions

Y N Convulsion/Epilepsy

Y N Rheumatic/Scarlet Fever

Y N Pregnancy

Y N Allergies to Latex Products

Y N Tuberculosis

Y N Diabetes

Y N Hemophilia/Blood Disorder

Y N Behavioral / Learning Disorders/ ADD

Y N Heart Disease/Murmur

Please discuss any medical conditions the child has had _____

Please list all medications the child is currently taking and why? _____

Have you ever been told your child requires antibiotics for dental work? _____

Please list all drugs the child is allergic to _____

Is your child adopted? **Y N**

Child's Physician _____

Phone (_____) _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date