Smile Station Pediatric Dentistry

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Tell Us About Your Child

Today's Date: ____________________ Best Phone # to Reach You at: ____________________ ☐ Mobile ☐ Home ☐ Work

Child's Name: ____________________ (First) ___ (M.I.) ____________________ (Last) Child's Birthdate: ______________ Child's Age: ______

Nickname: ____________________ ☐ Male ☐ Female School: ______________________________ Grade: ______

Child's Home Address: ____ (City) (State) (Zip)

What patient or physician can we thank for referring you? ____

Parent's Information

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Remarried ☐ Single ☐ Partnered

Mother Name: ____________________ (First) ___ (M.I.) ____________________ (Last) Social Security #: ____________________

Birthdate: ____________________ E-mail Address: ____

Address: ____ (City) (State) (Zip)

Employer: ____

Home Phone# : ____________________ Work Phone #: ____________________ Cell Phone #: ____________________

Father Name: ____________________ (First) ___ (M.I.) ____________________ (Last) Social Security #: ____________________

Birthdate: ____________________ E-mail Address: ____

Address: ____ (City) (State) (Zip)

Employer: ____

Home Phone# : ____________________ Work Phone #: ____________________ Cell Phone #: ____________________

Insurance Information

Primary Insurance Dental Coverage? ☐ Yes ☐ No

Insured's Name: ____________________ (First) ___ (M.I.) ____________________ (Last) Relationship to Patient: ____________________

Insured's Birthdate: ________________ Insured's ID #: ____________________ Insured's Employer: ____________________

Employer's Address: ____

Insurance Co. Name: ____________________ Phone #: ________________ Group # *(Plan, Local, or Policy#)*: __________

Insurance Co. Address: ____

Secondary Insurance Dental Coverage? ☐ Yes ☐ No

Insured's Name: ____________________ (First) ___ (M.I.) ____________________ (Last) Relationship to Patient: ____________________

Insured's Birthdate: ________________ Insured's ID #: ____________________ Insured's Employer: ____________________

Employer's Address: ____

Insurance Co. Name: ____________________ Phone #: ________________ Group # *(Plan, Local, or Policy#)*: __________

Insurance Co. Address: ____

Dental History

Is the child currently in pain? ☐ Yes ☐ No What is the primary reason for today's visit? ____________________

Has the child experienced problems with previous dental work? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Has the child had sealants in the past? ☐ Yes ☐ No

What is the date of the last dental xray?: ____________________

☐ Previous ☐ Present Dentist: ____________________ Date of Last Visit: __________ Ph #: __________

Why did you leave your previous dentist?: ____________________

What did you like most about any dentist you have seen?: ____________________

What did you dislike about any dentist you have seen?: ____________________

How do you think your child will do today?: ____________________

Does/did the child have any of the following habits?

☐ Yes ☐ No Lip Sucking/Biting
☐ Yes ☐ No Mouth Breather
☐ Yes ☐ No Used Pacifier
☐ Yes ☐ No Nursing Bottle Habits
☐ Yes ☐ No Clenching/Grinding Teeth
☐ Yes ☐ No Nail Biting
☐ Yes ☐ No Speech Problems
☐ Yes ☐ No Tongue Thrust
☐ Yes ☐ No Tongue/Cheek Biting
☐ Yes ☐ No Thumb/Finger Sucking
☐ Yes ☐ No Chewing on Objects
☐ Yes ☐ No Breast Fed

Medical History

Child's Physician: ____________________ Phone #: ____________________ Date of Last Visit: __________

Address: ____________________

Is the child currently under the care of a physician? ☐ Yes ☐ No Please explain: ____________________

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor ***Are immunizations current?*** ☐ Yes ☐ No

Please list all of the drugs that the child is currently taking: ____________________

Is your child allergic to any of the following: ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ **Latex** ☐ Local Anesthetics ☐ Nut Allergy

Does your child have any medical conditions that require Pre-Med? Yes No

Has the child had/experienced any of the following:

☐ Yes ☐ No Abnormal Bleeding
☐ Yes ☐ No Anemia
☐ Yes ☐ No Any Hospital Stay/Operations
☐ Yes ☐ No Asthma
☐ Yes ☐ No Autism Spectrum
☐ Yes ☐ No Birth Defects
☐ Yes ☐ No Blood Transfusions
☐ Yes ☐ No Cancer
☐ Yes ☐ No Cerebral Palsy
☐ Yes ☐ No Chronic Ear Infections/Tubes
☐ Yes ☐ No Cystic Fibrosis
☐ Yes ☐ No Delayed Speech Development
☐ Yes ☐ No Developmental Delay
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Down Syndrome
☐ Yes ☐ No Emotional/Psychiatric Problems
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Food Allergies
☐ Yes ☐ No G-Tube Feeding
☐ Yes ☐ No Hearing Loss/Impairment
☐ Yes ☐ No Heart Condition/Murmur
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No HIV/AIDS
☐ Yes ☐ No Hyperactivity/ADHD
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Learning Disabilities
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Muscular Dystrophy
☐ Yes ☐ No Radiation Therapy
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Seizures
☐ Yes ☐ No Seasonal Allergies
☐ Yes ☐ No Sickle Cell Anemia
☐ Yes ☐ No Skin Disorders
☐ Yes ☐ No Sleep Apnea/Snoring
☐ Yes ☐ No Spina Bifida
☐ Yes ☐ No Tonsillitis
☐ Yes ☐ No Tuberculosis (TB)
☐ Yes ☐ No Tumors
☐ Yes ☐ No Syndrome (specify)
____
____

Please explain any Yes answers: ____________________

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Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that 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 services that my child may need. I assign the Doctor to all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

Signature: ____________________ Date: ____________________

Printed Name: ____________________