



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: _____ Child's Birthdate: _____ Child's Age: _____
First M.I. Last

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: _____ Social Security #: _____
First M.I. Last

Birthdate: _____ E-mail Address: _____

Address: _____
City State Zip

Employer: _____

Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Father Name: _____ Social Security #: _____
First M.I. Last

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: _____ Relationship to Patient: _____
First M.I. Last

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: _____ Relationship to Patient: _____
First M.I. Last

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: _____

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: _____