WELCOME - Child Dental

To assist us in providing the most comprehensive care, please provide the following information.

PATIENT INFORMATION

Name: _____ Nickname: _____
First Middle Last
Date of Birth: _____/_____/_____ Age: _____ Sex: _____ School: _____ Grade: _____
Emergency Contact: _____ Phone #: _____
How did you hear about our office? _____

MOTHER

Name: _____
First Middle Last
Home Address: _____
City: _____State: _____ Zip: _____
Home Phone #: (_____) _____Cell #: (_____) _____
Email: _____
Employed by: _____
Work Phone #: (_____) _____
Social Security #: _____DOB:_____

FATHER

Name: _____
First Middle Last
Home Address: _____
City: _____State: _____ Zip: _____
Home Phone #: (_____) _____Cell #: (_____) _____
Email: _____
Employed by: _____
Work Phone #: (_____) _____
Social Security #: _____DOB:_____

INSURANCE INFORMATION

Policy Holder: _____ Date of Birth: _____ Social Security #: _____
Member ID #: _____ Group #: _____
Employer Name and Address: _____
Relationship to Patient: _____
Name of Insurance Company: _____ Telephone # of Insurance Company: (_____) _____
Address to Send Dental Claims: _____

AUTHORIZATION

I understand that the information is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of changes in medical status.

Child Consent:

I am the parent, guardian, or personal representative of _____. There are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above.

Insurance Assignment and Release:

I certify that my dependent is covered by insurance with _____. I assign directly to A Smile 4U all insurance benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

A Smile 4U may use my child's health care information and may disclose such information to the above-named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Date

PLEASE COMPLETE BOTH SIDES

PATIENT MEDICAL HISTORY

Patient's Physician: Name: _____ Phone #: _____

Date of last physical examination: _____ Are you currently under the care of a physician? Yes No

If *yes*, explain: _____

For Women: Are you taking birth control pills? Yes No / Are you pregnant? Yes No - Due Date: _____ / Are you nursing? Yes No

Please list current prescription medications: _____

Y N Have you taken (currently or previously) bone loss prevention medication such as Fosamax, Actonel, or Boniva?

Are you allergic to any of the following:

Y N Aspirin Y N Amoxicillin Y N Augmentin Y N Biaxin Y N Codeine Y N Dental Anesthetics
Y N Erythromycin Y N Ibuprofen Y N Keflex Y N Latex Y N Metals Y N Omnicef
Y N Penicillin Y N Sulfa Y N Tetracycline Y N Zithromax

Other, if not listed: _____

Do you currently have or have you had the following:

Y N ADD/ADHD
Y N Alcohol/Drug Dependency
Y N Anemia
Y N Anorexia/Bulimia
Y N Artificial Joint(s) (hip/knee)
Y N Asthma
Y N Autism/Asbergers
Y N Bleeding Abnormally with Extraction
Y N Blood Disease
Y N Cardiac Pacemaker
Y N Cancer / Chemotherapy / Radiation Treatment
Y N Congenital Heart Defect
Y N Cough (Chronic)
Y N Cold Sores/Fever Blisters
Y N Diabetes
Y N Emphysema
Y N Environmental Allergies
Y N Epilepsy or Seizures
Y N Fainting
Y N Headaches (Frequent)
Y N Hearing Concerns
Y N Heart Attack History
Y N Heart Disease/Angina
Y N Heart Murmur
Y N Heart Surgery
Y N Heart Valve Defect
Y N Hemophilia/Blood Transfusion
Y N Hepatitis (A, B, C) / Liver Disease
Y N High Blood Pressure
Y N HIV+ / AIDS
Y N Kidney Disease
Y N Low Blood Pressure
Y N Lupus
Y N Mitral Valve Prolapse
Y N Nervousness/Anxiety
Y N Pre-Medication (Antibiotic before Dental)
Y N Psychiatric Care
Y N Respiratory Disease
Y N Rheumatic/Scarlet Fever
Y N Chicken Pox/Shingles
Y N Sexually Transmitted Disease
Y N Shortness of Breath
Y N Sickle Cell Disease
Y N Sinusitis
Y N Smoke or Tobacco Use
Y N Stroke
Y N Thyroid Disease
Y N Tuberculosis

PATIENT DENTAL HISTORY

Do you currently have or have you had the following?

Y N Teeth sensitivity to hot, cold &/or sweet
Y N Frequent fever blisters, mouth ulcers
Y N Burning of tongue &/or cracking of the corners of mouth
Y N Had permanent teeth removed (wisdom teeth)
Y N Any head, neck or jaw injuries
Y N Any popping, clicking or soreness of the jaws
Y N Clench and/or grind teeth
Y N Do you wear night guards?
Y N Wear dentures and/or partials
Y N Concerns with teeth/fillings breaking
Y N Concerns with teeth, gums, or mouth
Y N Do you brush 2 times per day?
Y N Do you floss daily?
Y N Does food catch between teeth?
Y N Do you have periodontal disease?
Y N Have you had scaling and root planing?
Y N Gum bleeding while brushing &/or flossing
Y N Unpleasant taste &/or odor in your mouth
Y N Do you chew on one side of your mouth?
Y N Do you bite your lips &/or cheeks?
Y N Are you a mouth breather?
Y N Sleep apnea
Y N Are you happy with your smile?
Y N Are you interested in braces (orthodontics)?

Frequency of brushing: _____
Frequency of flossing: _____
Recent Dental Check-up/Cleaning:
Date: _____ By Whom: _____
Date of Last: Panoramic Radiograph _____
Bitewing Radiographs _____

DR. HAS REVIEWED THE PATIENT MEDICAL & DENTAL HISTORY:

DR'S INITIALS _____ DATE: _____