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Forever Smiles Pediatric Dentistry

Date: ___/___/__

PATIENT INFORMATION

Child's Full Name____ Age ________ Sex (M) (F)

Nickname (if any) ________________________________Birth Date _________________________________

Whom may we thank for referring you ____

GENERAL INFORMATION

Parent/Legal Guardian (full name) ___________________________________ Birthdate: ___/___/___

Relationship to Child _________________________________ SSN: ______-____-______

Home Address ____

Home Phone ________________________ Cell Phone_________________

Email address _______________________________________

Employer ____ Job Title ______________________

Work Address ____

Work Phone _____________________________________

Is it okay to contact this parent via: Home Work Cell Email

Parent/Legal Guardian (full name) ___________________________________ Birthdate: ___/___/___

Relationship to Child _________________________________ SSN: ______-____-______

Home Address ____

Home Phone ________________________ Cell Phone_________________

Email address _______________________________________

Employer ____ Job Title ______________________

Work Address ____

Work Phone _____________________________________

Is it okay to contact this parent via: Home Work Cell Email

Parent(s) are: Married Divorced Single Widowed Partners

Child lives with: _____________________________________

Who is responsible for the account? ______________________________

SOCIAL HISTORY

What is your child most interested in? ____

Names of brothers/sister____ Is your child adopted? (Y) (N)

Name of Pets____

Reason for today's visit ____

Child's school____

HEALTH HISTORY

Child's pediatrician: __________________________________Telephone #___________________

Allergies (if YES, see below)	(Y)	(N)	Hearing Impaired	(Y)	(N)
Congenital Heart Problems / Heart Murmurs / Rheumatic Fever	(Y)	(N)	Bone Disorder	(Y)	(N)
Premature birth	(Y)	(N)	Cancer/Malignancy	(Y)	(N)
Growth & Development (learning, behavioral)	(Y)	(N)	Diabetes/Endocrine	(Y)	(N)
Down's Syndrome	(Y)	(N)	Brain Injury	(Y)	(N)
Autism	(Y)	(N)	Central Nervous System/Epilepsy/Seizure	(Y)	(N)
Learning disabilities/ADHD/ADD	(Y)	(N)	Cerebral Palsy	(Y)	(N)
Asthma / Respiratory System / Pneumonia	(Y)	(N)	Hepatitis or Liver Disease	(Y)	(N)
Cystic Fibrosis	(Y)	(N)	GI (stomach, intestinal) / Eating Disorder	(Y)	(N)
Tuberculosis	(Y)	(N)	Bladder problems	(Y)	(N)
Anemia	(Y)	(N)	Extremities/Arthritis/Joint problems	(Y)	(N)
Hemophilia/Blood Disorders / Bruising	(Y)	(N)	Emotional/School Problems/Depression/Anxiety	(Y)	(N)
Skin Problems / Cold Sores / Canker Sores	(Y)	(N)	Hospitalizations/Surgeries	(Y)	(N)
Earaches/Infections	(Y)	(N)	OTHER	(Y)	(N)

Has your child had any unfavorable reactions to drugs, antibiotics, or anesthetics? (Y) (N)

If yes, please list ____

Does your child currently have OR has your child ever had a history of any of the following?

If you replied YES to any of the below, please explain: ____

____

____

Is your child currently taking any **MEDICATIONS**? (Y) (N) If YES, what kind? ____

Is your child protected by immunizations? (Y) (N) ___________________________

Is your child taking any supplemental fluoride? (Y) (N) If yes, how? ______________________________

Does your child have an **ALLERGIC REACTION** to: (Please check all that apply) ____NO KNOWN ALLERGIES ____Medications ____Latex/Rubber ____Pollen/Dust ____Anesthetic ____ Animals (Dogs/Cats) ____Acrylic ____Dyes/Coloring ____Other Foods

If so, please list: ____________________________________

Dental History

Is this your child's dental first visit? (Y)(N) If no, previous dentist? _________________________Phone ________________

Date of last visit _______________How was his/her experience? _________________________ Were X-rays taken? (Y) (N)

Has your child had any injuries to teeth, mouth or head? (Y)(N) Please describe: ____________________________________

Does your child have any of the following habits? (past or present)? Please circle: Thumb/finger-sucking Pacifier

Nail-biting Lip-sucking Mouth-breathing Teeth-Grinding Snoring Bottle-feeding

Does your child currently use a bottle? (Y) (N) If yes, how often during the day? ______________________

Is the bottle used at night? (Y) (N) What do you put in the bottle? ________________ Does your child currently nurse? (Y) (N)

How often does your child brush his/her teeth per day? ______ Do you help? (Y) (N)

How often does your child floss? _______________________ Do you floss your child's teeth? (Y) (N)

How can we make this a positive experience for your child today? ____

____

The permission of parent or guardian is necessary for dental treatment of a minor. I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's health status. I authorize the dental staff to perform any necessary dental services my child may need. I understand that by signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage. I further understand that all payments are due and payable on the day services are rendered.

Parent/Guardian Signature: ____ Date_______________

Doctor's Signature: ____ Date_______________

Insurance Information

Primary Insurance Company ____Phone Number _____________________

Policy Owner's Name _______________________________ Relationship to Child _______________________________

Birthdate: ___/___/___ SSN or Alternate ID#: _____________________________ Group #: ____________________

Secondary Insurance Company ____Phone Number _____________________

Policy Owner's Name _______________________________ Relationship to Child _______________________________

Birthdate: ___/___/___ SSN or Alternate ID#: _____________________________ Group #: ____________________

As a courtesy to our patients, we will file your insurance claim with the insurance company listed above for treatments your child receives. However, in the event the insurance company, for any reason, does not pay, the balance will become your responsibility, and will be billed directly to you. You understand that this contract is with Forever Smiles Pediatric Dentistry and yourself, and you are responsible for all charges on the account.

SIGNATURE OF RESPONSIBLE PARTY ____

Relationship ____ Date _____________________________