WELCOME

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Child's Information

Today's Date: _____

Child's Name: _____
Last First MI

Child's Nickname: _____

Child's Age: _____ ☐ Male ☐ Female

Child's Birthdate: _____/_____/_____ S.S. # _____

School: _____ Grade: _____

Child's Home Phone Number: ( ) _____

Child's Home Address: _____
Street Apt/Condo#

_____
City State Zip Code

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have custody of this child or are you the guardian?

☐ Yes ☐ No

Whom may we Thank for referring you: _____

Parent's Information

Who is responsible for the account? _____

Parent/Guardian's Name: _____

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

Parent's Birthdate: _____/_____/_____ S.S. # _____

Home Phone Number: ( ) _____

Cell Phone Number: ( ) _____

Address (if different from child's): _____
Street Apt/Condo#

_____
City State Zip Code

Email Address: _____

Employer: _____

Work Phone Number: ( ) _____ Ext. _____

If you have dental insurance coverage for the child, please fill out below.

Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's S.S. # _____

Emergency Contact Information

Name: _____ Phone Number: ( ) _____

Address: _____
Street Apt/Condo# City State Zip Code

Release Information

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Parent's Signature Date

Parent Permission Policy

I give Kids Smiles permission to see my child(ren) in my absence. I understand that this consent consists of any treatment not limited to but including fillings, sealants, nerve treatments, and children's crowns/ caps. In order to complete treatment, topical and/or local anesthetic may be used, and my child's hands may need to be restrained.

As my child is a minor, I understand that someone over the age of 18 must accompany my child(ren) to the office and remain there for the duration of their appointment. I give consent for that person to make any decision concerning my child's treatment.

I understand that a parent or legal guardian must be present at their initial and six-month visits in order to present and update treatment plans for my child to be seen.

I also consent to my child's name and birth date being placed on the outside of their chart. I understand that Kids Smiles will keep this information as private as possible.

_____
Parent's Signature Date

Dental & Medical History

Tell us why you brought the child to the dentist today: _____

_____

_____

Has the child ever taken any diet pills such as Phen-fen (also known as Redux or Pondimin)? ☐ Yes ☐ No

If so, when? _____

Is the child currently in pain? ☐ Yes ☐ No

Does the child need antibiotics before dental treatment? ☐ Yes ☐ No

If yes, why? _____

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water flouridated? ☐ Yes ☐ No

Is the child taking flouridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

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

Is the child currently under the care of a physician? ☐ Yes ☐ No

Child's Physician: _____

Phone Number: ( ) _____ _____
Date of last visit

Previous/Present Dentist: _____

Phone Number: ( ) _____ _____
Date of last visit

How would you describe the child's current physical health? ☐ Good ☐ Fair ☐ Poor

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking:

_____

_____

Aside from the items below, list all other drugs/things that the child is allergic to:

_____

Latex ☐ Yes ☐ No Nickel/Metals ☐ Yes ☐ No

Plastic ☐ Yes ☐ No Nut/Tree nut/Peanut ☐ Yes ☐ No

Dental & Medical History Continued...

Has the child experienced the following medical problems?

ADD/ADHD	☐ Yes	☐ No	Abnormal Bleeding / Hemophilla	☐ Yes	☐ No
AIDS/HIV+	☐ Yes	☐ No	Artificial Bones / Joints / Valves	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Congenital Heart Defect	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Handicaps or Disabilities	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Developement Issues	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Kidney or Liver problems	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No			
Heart Murmur	☐ Yes	☐ No			
Hepatitis	☐ Yes	☐ No			
Hives	☐ Yes	☐ No			
Lupus	☐ Yes	☐ No			
Measles	☐ Yes	☐ No			
Mononucleosis	☐ Yes	☐ No			
Prosthetics	☐ Yes	☐ No			
Rheumatic Fever	☐ Yes	☐ No			
Scarlet Fever	☐ Yes	☐ No			
Sickle Cell Disease	☐ Yes	☐ No			
Skin Rash	☐ Yes	☐ No			
Tuberculosis (TB)	☐ Yes	☐ No			
Born Prematurely If yes, at what week?	☐ Yes	☐ No			

Are child's immunizations current? ☐ Yes ☐ No

Had any hospital stays / operations ☐ Yes ☐ No If yes, when & why?

_____

_____

_____

Is there anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Did the child experience any of the following? (check all that apply)

- ☐ Breast Fed
- ☐ Chewing on Objects
- ☐ Clenching / Grinding Teeth
- ☐ Lip Sucking / Biting
- ☐ Mouth Breather
- ☐ Nail Biting
- ☐ Nusing Bottle Habits
- ☐ Speech Problems
- ☐ Thumb / Finger Sucking
- ☐ Tongue / Cheek Biting
- ☐ Tongue Thrust
- ☐ Used a Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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.

_____
Parent's Signature Date

OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent or guardian and patent named herein.

_____
Dentist's Signature Date

Dentist's Comments: _____

_____

_____

Clearance required? ☐ Yes ☐ No

Medical History Update

Has there been any change in the child's health status since their last visit? If so, please explain. Be sure to include new medication(s) or discontinued medication(s).

_____
Signature of Parent or Guardian Date

_____
Signature of Parent or Guardian Date

Has there been any change in the child's health status since their last visit? If so, please explain. Be sure to include new medication(s) or discontinued medication(s).

_____
Signature of Parent or Guardian Date

_____
Signature of Parent or Guardian Date