KidSmiles Pediatric Dentistry

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Child's Name_____Date of Birth_____Male___Female___Age_____
Last Dental Visit_____Child's Previous Dentist_____
Purpose of this Visit_____
Who may we thank for referring you to our office _____
Child's School_____Names of Child's Siblings_____

Health History

Child's Physician_____
Is your child adopted? ___Yes ___No If yes, is your child aware?_____
Is your child up to date with immunizations? ___Yes ___No ___If not, please explain:
Is your child under a physician's care now?_____Reason_____
Is your child taking any medication or drugs?_____What kind_____Reason_____
Is your child allergic to any medication?_____Please List _____
Does your child have allergic reaction(s) to: food_____animals ____pollen ____dust___latex____other_____
Does your child have any of these habits: finger/thumb habit____pacifier____nail biting____teeth grinding
lip sucking____snoring____mouth breathing____nursing bottle ____
Has your child had any injuries to teeth, mouth or head?____Describe_____
Has your child had a history or difficulty with any of the following?

YES	NO		YES	NO		YES	NO		YES	NO	
☐	☐	Premature Birth	☐	☐	Delayed Development	☐	☐	Emotional Problems	☐	☐	Nosebleeds
☐	☐	Heart	☐	☐	Motion Sickness	☐	☐	Speech Disorder	☐	☐	Asthma
☐	☐	Seizures	☐	☐	Earaches	☐	☐	Hearing	☐	☐	Liver
☐	☐	Immune Disorder	☐	☐	Kidney	☐	☐	Bone Disorder	☐	☐	Cerebral Palsy
☐	☐	Brain Injury	☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐	Bruising
☐	☐	Fainting or dizziness	☐	☐	Tuberculosis	☐	☐	Hepatitis	☐	☐	Bladder
☐	☐	Anemia	☐	☐	Cancer or Malignancies						

General Information

Parent/Guardian #1_____SSN_____DOB_____
Address_____City_____Zip Code_____
Home Phone_____Cell Phone_____Email_____
Relationship to Patient_____Employer/Occupation_____Work Phone _____
Parent/Guardian #2_____SSN_____DOB_____
Address_____City_____Zip Code_____
Home Phone_____Cell Phone_____Email_____
Relationship to Patient_____Employer/Occupation_____Work Phone _____

Insurance Information

Do you have dental insurance coverage for your child? _____
Name of Insured_____ Name of Insurance Company_____
Group #_____ID#_____Address of Ins. Company _____
IF YOU HAVE DUAL COVERAGE, PLEASE COMPLETE BELOW FOR SECONDARY CARRIER;
Name of Insured_____Name of Insurance Company_____
Group #_____ID#_____Address of Ins. Company _____

The permission of parent or guardian is necessary for dental treatment. I give the dentists permission to use such measures as deemed necessary in their professional judgment to render the best dental treatment for my child including the use of anesthetics and medication considered necessary. Parents will be consulted before any treatment is started.

Signature_____Relationship_____Date _____