Kids Healthy Smiles

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____ PREFERRED NAME: _____
BIRTH DATE: _____/_____/_____ AGE: _____ WEIGHT: _____ SCHOOL: _____GRADE: _____
ADDRESS: _____CITY: _____STATE: _____ZIP: _____
HOME #: _____ CELL #: _____ EMAIL: _____
PATIENT LIVES WITH: MOTHER ( ) FATHER ( ) OTHER ( ) RELATIONSHIP TO CHILD: _____
PERSON RESPONSIBLE FOR ACCOUNT: _____MOTHER ( ) FATHER ( ) OTHER ( ) RELATIONSHIP TO CHILD: _____
RESPONSIBLE PARTY ADDRESS: _____ CITY: _____STATE: _____ZIP: _____
WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

PARENT GUARDIAN 1

NAME: _____
ADDRESS SAME AS PATIENT? ___ YES ____ NO EMAIL _____
PHONE #1 _____ PHONE # 2 _____
BIRHT DATE: _____ SOS. SEC: _____

PARENT GUARDIAN 2

NAME: _____
ADDRESS SAME AS PATIENT? ___ YES ____ NO EMAIL _____
PHONE #1 _____ PHONE # 2 _____
BIRHT DATE: _____SOS. SEC: _____

DENTAL INSURANCE

NAME OF INSURED: _____ INSURED BIRTH DATE: _____ RELATIONSHIP TO INSURED: _____
INSURED SOC. SEC: _____ SUSCRIBER ID: _____ GROUP #: _____
INSURED EMPLOYER: _____INSURED COMPANY: _____INSURANCE PHONE: _____
IF INSURED IS NOT RESPONSIBLE PARTY PLEASE PUT INSURED ADDRESS HERE: _____
IF THERE IS SECONDARY INSURANCE, PLEASE PUT INFORMATION HERE: _____

MEDICAL HISTORY

CHILD'S PEDIATRICIAN OR PRIMARY CARE PHYSICIAN'S NAME, ADDRESS AND PHONE NUMBER (IF AVAILABLE)
_____
PLEASE INDICATE YES OR NO IN RESPONSE TO THE FOLLOWING QUESTIONS:
___ YES ___ NO DOES YOUR CHILD REQUIRE ANTIBIOTIC PREMEDICATION BEFORE DENTAL TREATMENTS (SBE PROPHYLAXIS)?
___ YES ___ NO HAS YOUR CHILD OR FAMILY MEMBERS EVER HAD COMPLICATIONS FOLLOWING A DENTAL TREATMENT, SEDATION, OR GENERAL ANESTHESIA?
___ YES ___ NO IS YOUR CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN DUE TO A SPECIFIC CONDITION?
___ YES ___ NO HAS YOUR CHILD EVER BEEN HOSPITALIZED DUE TO A SURGERY OR ILLNESS?
___ YES ___ NO DOES YOUR CHILD HAVE SNORING, OBSTRUCTIVE SLEEP APNEA, OR MOUTH BREATHING?
IF ANY OF THE PREVIOUS QUESTIONS ARE MARKED YES, PLEASE EXPLAIN: _____
_____
IS YOUR CHILD TAKING ANY PRESCRIPTION OR NON-PRESCRIPTION MEDICATIONS? ____ YES ____ NO
IF YES, PLEASE LIST BELOW, MEDICATION NAMES, DOSAGE, FREQUENCY TAKEN, AND WHAT CONDITIONS THEY ARE TAKEN FOR:
_____
_____
IS YOUR CHLD ALLERGIC TO: ___ ASPIRIN ___ CODEINE ___ ERYTHTOMYCIN ___ LATEX (RUBBER) ___ PENICILLIN ___ SULFA ___ OTHER _____
HAS YOUR CHILD HAD ANY OF THE FOLLOWING:

___ ADHD	___ CANCER	___ EXCESSIVE BLEEDING	___ HEPATITIS	___ MENTAL DISORDER	___ SINUS PROBLEMS
___ ANEMIA	___ CEREBRAL PALSY	___ FAINTING	___ HEARING PROBLEMS	___ NERVOUS DISORDER	___ STOMACH PROBLEMS
___ ARTIFICIAL JOINTS	___ CLEFT LIP/PALATE	___ GLAUCOMA	___ HIGH BLOOD PRESSURE	___ RADIATION TREATMENT	___ STROKE
___ ASTHMA	___ DIABETES	___ HEAD INJURY	___ HIV/AIDS	___ RESPIRATORY PROBLEMS	___ SIGHT PROBLEMS
___ AUTISM	___ DEVELOPMENT DIS	___ HEART DISEASE	___ JAUNDICE	___ RHEUMATIC FEVER	___ SPEECH PROBLEMS
___ BLOOD DISEASE	___ EPILEPSY/SEIZURE	___ HEART MURMUR	___ KIDNEY/LIVER DISEASE	___ RHEUMATISM	___ TUBERCULOSIS

PLEASE EXPLAIN ANY MARKED ANSWERS: _____
DOES YOUR CHILD HAVE ANY OTHER CONDITIONS, DISEASES, OR ALLERGIES, ETC? _____
TEENAGE FEMALE PATIENT ONLY: IS YOUR TEEN PREGNANT? IF YES, WHEN IS DUE DATE? _____

DENTAL HISTORY

HOW FREQUENTLY DO ___ YOU ___ YOUR CHILD BRUSH HIS/HER TEETH? ___ 3 (+) A DAY ___ TWICE A DAY ___ ONCE A DAY ___ SELDOM
HOW FREQUENTLY DO ___ YOU ___ YOUR CHILD FLOSS HIS/HER TEETH? ___ 1 (+) A DAY ___ FEW TIMES A WEEK ___ SELDOM
PLEASE INDICATE YES OR NO TO THE FOLLOWING QUESTIONS (IF YES IS INDICATED, PLEASE ELABORATE):
___ YES ___ NO HAS YOUR CHILD PREVIOUSLY BEEN TO THE DENTIST? IF YES, WERE X-RAYS TAKEN ___ YES ___ NO DENTIST NAME _____
___ YES ___ NO DOES YOUR CHILD'S GUM BLEED DURING BRUSHING OR FLOSSING? _____
___ YES ___ NO DOES YOUR CHILD EXPERIENCE TOOTH SENSITIVITY TO COLD OR HOT TEMPERATURES? _____
___ YES ___ NO IS YOUR CHILD EPERIENCING ANY TOOTH OR JAW PAIN/TENDERNESS? _____
___ YES ___ NO DOES YOUR CHILD GRIND HIS/HER TEETH? _____
___ YES ___ NO HAS YOUR CHILD HAD ANY INJURIES TO HIS/HER TEETH? _____
___ YES ___ NO HAS YOUR CHILD EVER HAD A TOOTH EXTRACTED? IF YES, WHERE THERE ANY PROBLEMS? ___ YES ___ NO _____

TO THE BEST OF MY KNOWLEDGE, THE QUESTIONS ON THIS FORMAT HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY CHILD'S HEALTH. IT IS MY RESPONSIBILITY TO INFORM THE DENTAL OFFICE OF ANY CHANGES TO PERSONAL AND MEDICAL INFORMATION.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ **DATE:** _____