GROWING SMILES
Pediatric Dentistry & Orthodontics

PATIENT INFORMATION

Child's Name (First/Middle/Last) _____

Birth Date _____ Social Security#_____ ☐ Male ☐ Female

Address: _____ Home#:_____

City:_____ State: _____Zip: _____

Has any member of your family been treated in our office? No Yes

Has your child been treated by another dentist? Yes / No, Dr. _____

Who may we thank for referring you to our office? _____

PARENT/GUARDIAN INFORMATION

☐ Mother ☐ Stepmother ☐ Guardian

Name (First/Middle/Last) _____

DOB: _____SS#: _____

Drivers License #: _____

Address: _____

City/State/Zip _____

Home#: _____

Cell/Work#: _____

Employer: _____

Email: _____

☐ Mother ☐ Stepmother ☐ Guardian

Name (First/Middle/Last) _____

DOB: _____SS#: _____

Drivers License #: _____

Address: _____

City/State/Zip _____

Home#: _____

Cell/Work#: _____

Employer: _____

Email: _____

INSURANCE INFORMATION

Please notify the office of any insurance changes at each visit that may affect your account. As a courtesy, we will bill your insurance company on your behalf. You are responsible for any remaining balance.

Subscriber (First/Middle/Last) _____

DOB: _____ID#: _____

Primary Insurance Co.:_____

Phone#: _____

Subscriber (First/Middle/Last) _____

DOB: _____ID#: _____

Secondary Insurance Co.:_____

Phone#: _____

EMERGENCY CONTACT

Person to contact in case of an emergency other then parent/guardian.

Name: _____Phone#: _____Alt#: _____

Address/City/State:_____

AUTHORIZATION

I hereby authorize direct payment to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I understand that any previous balances must be paid before future care will be given. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history are correct to the best of my knowledge and may be used to contact me at anytime.

SIGNATURE OF RESPONSIBLE PARTY ☐ Mother ☐ Father ☐ Guardian ☐ Self

X_____Date: _____

Last Name: _____First Name:_____

DENTAL AND MEDICAL HISTORY QUESTIONNAIRE (Please answer every question.)

Yes No 1. Has the child had any unusual or unpleasant experiences in a dental or medical office?
Yes No 2. Has the child had any injuries to the face, mouth or teeth?
Yes No 3. Was the child breast fed? How long? _____
Yes No 4. Does the child have any oral habits such as thumb sucking or sleeping with a bedtime bottle?
Yes No 5. Is there a chief concern regarding the child's oral health? Explain:_____
Yes No 6. Is the child presently in good health?
Yes No 7. Are the child's immunizations current? Child's Physician: _____
Yes No 8. Has the child been in a hospital or had surgery? Describe: _____

9. Please describe any current medical treatment, pending surgery, recent injury or any other information:
_____

Yes No 10. Is the child taking any medications at this time? List: _____
_____

Yes No 11. Does the child attend any class or school?
Yes No 12. Does the child have any abnormal behavior? Describe: _____
Yes No 13. Were there any problems during pregnancy, delivery or during the child's first year of life?
Yes No 14. Has the child had any unusual reaction or allergy to medications such as penicillin, aspirin, or local anesthetics?
Yes No 15. Does the child have a history of allergies? List:_____
Yes No 16. Is the child pregnant?

17. Do you obtain your drinking water from ☐ A Well ☐ Bottled Water ☐ A Water Purifier ☐ City Water

MEDICAL DIAGNOSIS HISTORY

Yes / No ADD/ADHD
Yes / No AIDS/HIV
Yes / No Anemia
Yes / No Asthma
Yes / No Autism/SID
Yes / No Behavior Problems
Yes / No Birth Defects
Yes / No Cancer or Tumors
Yes / No Cerebral Palsy
Yes / No Cognitively Impaired
Yes / No Convulsions/Seizures

Yes / No Diabetes
Yes / No Ear Infections
Yes / No Epilepsy
Yes / No Unusual Bleeding
Yes / No Faintness/Dizziness
Yes / No Heart Murmur
Yes / No Heart Trouble
Yes / No Hearing Problems
Yes / No Hepatitis
Yes / No High Blood Pressure
Yes / No High Fevers

Yes / No Kidney Disease
Yes / No Learning Disability
Yes / No Liver Disease
Yes / No Nutritional Problem
Yes / No Rheumatic Fever
Yes / No Sickle Cell Disease/Trait
Yes / No Speech Problems
Yes / No Tonsillitis
Yes / No Tuberculosis
Yes / No Vision Problems
Yes / No Other

Doctors Use Only CRA: ☐ L ☐ M ☐ H Mother ☐ L ☐ M ☐ H Father ☐ L ☐ M ☐ H Sibling Order _____