Smile Stars Pediatric Dentistry

Health History and Patient Information

Patient Information

Child's First / Last Name	Preferred name	Birth date	Age	Male/Female

- -

Social Security #	School	Grade	Weight	Height

Mailing address	City	Zip	State

( )

Home Phone #	Reason for today's visit

*Who referred you to our office? (We wish to thank them)___________________________

Medical History

( )

Child's Physician	Phone #	Date last seen (Mo/Yr)

	Yes	No
Is your child currently under the care of a physician for any medical problems? If yes, for what? ____	_____	_____
Is your child currently taking any medicine? If yes, what? ____	_____	_____
Is your child allergic to any food or medicine? If yes, what? ____	_____	_____
Has your child ever been hospitalized or had surgery? If yes, for what? ____	_____	_____
Has your child ever received general anesthesia or sedation? If yes, when? ______________ Any unfavorable reaction? ________________	_____	_____

Has your child been treated for any of the following medical conditions:

Y N Abnormal Bleeding	Y N Allergy	Y N Anemia
Y N Arthritis	Y N Asthma	Y N Autism
Y N Brain injury	Y N Bronchitis	Y N Convulsions/Seizures
Y N Cancer	Y N Cerebral Palsy	Y N Cleft lip/palate
Y N Developmental delay	Y N Diabetes	Y N Eye Problems
Y N Fainting	Y N Hearing loss	Y N Hepatitis
Y N Hemophilia	Y N Heart disease	Y N Heart murmur
Y N HIV/AIDS	Y N Mental Retardation	Y N Kidney disease
Y N Liver disease	Y N Respiratory problems	Y N Rheumatic fever
Y N Sinus problems/snoring at night	Y N Skin rashes	Y N Scoliosis

Y N Other____

Please rate your child's current physical health: Good Fair Poor

Pharmacy____________________________________ Phone #___________________________

Dental History

Patient Name______________ Date of Birth_____________

Has your child been to the dentist before? Y N
If yes, previous dentist and date of last visit: ____________________

Are there any dental problems that you are aware of? Y N
If yes, please explain: ____________________

Has your child experienced any unfavorable reaction to medical or dental care? Y N
If yes, please explain: ____________________

How do you think your child will react to the dentist? ____________________

How often does your child brush? ___________Is it supervised?_________ By Whom? ______________
Does your child floss? Y N Is your child receiving fluoride in water or vitamins? Y N

Does your child have any of the following habits:

Y N Thumb/finger sucking Y N Pacifier sucking Y N Bottle/breast feeding (>1 year old)
Y N Sippy cup Y N Nail biting Y N Lip biting/sucking
Y N Mouth breathing Y N Grinding/clenching Y N Other ______________________

Family information

Father's full name: __________________________SS#_____________________DL#_______________
Mailing address: ____________________
Occupation: ________________________________ Employer: ___________________________
Home #: _____________________ Work #: ____________________ Cell #: _______________________
E-Mail: ____________________
Mother's full name: __________________________ SS#: ___________________ DL# ______________
Mailing address: (if different) ____________________
Occupation: ______________________________ Employer: ______________________________
Home #: ____________________ Work #: _____________________ Cell #: ________________________
E-mail: ____________________
Siblings (names and ages): ____________________
Has any member of your family been a patient of this office before? Y N Name: ________________

***In case of an emergency, who should we contact?**
Name: ___________________________________ Relationship: ________________________________
Address: ____________________
Phone # 1:______________________________ Phone # 2: _____________________________________

Insurance and financial responsibility

Is your child covered by a dental insurance plan? Y N Name of Insurance: ___________________
Name of parent insured: ______________________________ Employed by: ________________________
SS#:____________________Insured DOB: ________________ Group or policy #: ___________________
Insurance company phone #: ___________________Person responsible for child's account: ____________

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes. I understand that payment is expected for service rendered at the time of service. I also understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.

Signature: ________________________Relationship to child: ___________ Date: _________