State Street Smiles

Welcome!

We would like to welcome you and your child to our office. The benefits of a happy, healthy smile are immeasurable. Our philosophy is to provide each patient with the highest quality dental care in a fun-filled and friendly environment. Please take a moment to fill out this form completely. The better we can communicate, the better we can care for you.

Tell Us About Your Child

Child's Name _____ Preferred Name _____ ☐ Male ☐ Female
Last First Initial

Date of Birth _____ Age _____ School _____ Grade _____
Child's Home Address _____ Home Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Names and ages brothers/sisters _____

Who is Accompanying the Child Today?

Name _____ Relationship _____ Do you have legal custody of this child? ☐ Yes ☐ No
In case of emergency contact (name and phone number) _____
Whom may we thank for referring you to our office? _____

Parent's Information

Mother's Name _____
Address _____
Employed by _____
Occupation _____
SS# _____
Date of Birth _____
Home Phone Number _____
Business Phone Number _____
Cell Phone Number _____
Email _____

Father's Name _____
Address _____
Employed by _____
Occupation _____
SS# _____
Date of Birth _____
Home Phone Number _____
Business Phone Number _____
Cell Phone Number _____
Email _____

Who is responsible for this account? _____ Relationship _____

Dental Insurance Information

Insurance Co. Name _____ Phone Number _____ Group/Policy Number _____
Insurance Company Address _____
Policy Holder _____ Relationship to Child _____
Do you have secondary dental insurance coverage? ☐ Yes ☐ No

Medical History

Pediatrician's/Physician's Name _____

Address _____ Phone _____

Date of last Physical exam _____ Describe your child's behavior at the pediatrician _____

Describe your child's current health ☐ Good ☐ Fair ☐ Poor Height _____Weight _____

Are your child's immunizations up to date? ☐ Yes ☐ No

What if any, medication(s) is your child currently taking? _____

Is your child presently under the care of a physician? _____

Has your child ever been hospitalized? ☐ Yes ☐ No If yes, please explain _____

Does your child have a history of any of the following medical problems (check all that apply):

- ☐ Abnormal Bleeding
- ☐ ADD/ADHD
- ☐ Allergies (antibiotics, local anesthetic, etc.)
- ☐ Anemia
- ☐ Asthma
- ☐ Autism/Spectrum Disorder
- ☐ Blood Transfusion
- ☐ Cancer
- ☐ Chronic Ear Infections
- ☐ Congenital Heart Defect
- ☐ Convulsions/Epilepsy
- ☐ Diabetes
- ☐ Handicaps/Disabilities
- ☐ Heart Murmur
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ HIV+/AIDS
- ☐ Kidney/Liver Condition
- ☐ Latex Allergy
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Other (please explain)

Explain any medical problems indicated above _____

_____

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

Dental History

Has your child received dental treatment before? ☐ Yes ☐ No

Name and address of previous dentist _____

When was your child's last visit to the dentist? _____ Why? _____

Did your child have any difficulty cooperating? ☐ Yes ☐ No Explain _____

Did your child have difficulty catching on to breastfeeding or bottle? ☐ Yes ☐ No

Has your child had any dental x-rays taken before? ☐ Yes ☐ No

What is your child's daily oral care routine? _____

Does your child brush his/her own teeth? ☐ Yes ☐ No

Does your child floss his/her own teeth? ☐ Yes ☐ No

Does anyone help/supervise your child's teeth brushing? ☐ Yes ☐ No

Does your child receive any form of fluoride (city/well water, vitamin supplements)? ☐ Yes ☐ No

Has your child experienced any trauma to the face or teeth? ☐ Yes ☐ No

Does your child have any oral habits (thumb sucking, nail/lip biting, pacifier, etc.)? ☐ Yes ☐ No

Has anyone in the family, including parents, had orthodontics (braces)? ☐ Yes ☐ No

Does your child use a bottle or sippy cup? ☐ Yes ☐ No

What snack foods does your child eat? _____

Have any teeth been removed in the past? ☐ Yes ☐ No Why? _____

Has your child had a toothache recently? ☐ Yes ☐ No Please explain _____

What is the reason for today's visit (1st exam, check-up, toothache, etc.)? _____

Consent:

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my child's medical status without fail. It is necessary, because my child is a minor that permission be obtained from a parent or guardian before necessary treatment is performed. My signature affixed below authorizes the dentists of State Street Smiles and their staff to provide my child's dental and related medical/surgical treatment as deemed necessary. Utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete such treatment, including diagnostic radiographs. I authorize the dentist to release any information including the diagnosis and the record of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that it is my responsibility to know the terms of my dental insurance contract (i.e. How often my insurance carrier will pay for exams and cleanings). This consent shall remain in full force and in effect until canceled by either party. I fully understand this authorization and have no further questions.

X _____ _____

Signature Date