Irmo SMILES

Pediatric Dentistry
Child Dental History

About Your Child

Child's Name _____ Nickname _____ DOB _____ Sex ○M ○F

Address _____ Contact Phone _____

Father's Name _____ Cell Phone _____ Work Phone _____

Mother's Name _____ Cell Phone _____ Work Phone _____

Responsible Party Name _____ DOB _____ SSN _____

Billing Address (if different from above) _____

Email Address (to receive appt. reminders/correspondence) _____

How did you hear about our office?

○Self ○Dentist ○ Insurance Company ○Online Search ○Others _____

Insurance Information

Subscriber's Name _____ DOB _____ SSN _____

Subscriber's Address (if different from above) _____

Subscriber's Phone (Cell) _____ Alternate Phone _____

Subscriber's Employer _____ Occupation _____

Name of Insurance Company _____

Insurance Company Phone _____ Group # _____ ID# _____

Dental History

Date of last dental visit _____ Name of previous Dentist _____

Reason for visit _____ Date of last dental x-rays _____

May we request prior records if necessary? ○ Yes ○ No

Has your child complained about dental problems? ○ Yes ○ No If yes, please explain. _____

_____

Has your child experienced any unpleasant dental experiences? ○ Yes ○ No If yes, please explain.

_____

Are there any oral habits we should know about? (thumb/pacifier/etc.) ○ Yes ○ No If yes, please explain.

_____

Does your child brush teeth daily? ○ Yes ○ No

Do lyou assist your child with teeth brushing? ○ Yes ○ No ○ Sometimes

Does your child take any fluoride supplementation? ○ Yes ○ No ○ Sometimes

Is dental floss used? ○ Yes ○ No ○ Sometimes

Has your child worn any orthodontic appliances, now or ever? ○ Yes ○ No If yes, please explain.

_____

Has your child suffered any injuries to mouth/teeth/head? ○ Yes ○ No If yes, please explain.

_____

How would you describe your child's overall attitude towards dentistry?

_____

Pediatric Dentistry
Child Health History

Health History

Child's Primary Care Physician _____

Physician phone _____ Office location _____

Is your child currently under the care of a physician/doctor/dentist? ○ Yes ○ No

If yes, please explain. _____

Is your child currently under the care of a psychiatrist/psychologist? ○ Yes ○ No

If yes, please explain. _____

Is your child currently taking any medications or drugs (vitamins, prescriptions, etc.?) ○ Yes ○ No

If yes, please explain. _____

Does your child experience any excessive bleeding when cut? ○ Yes ○ No

If yes, please explain. _____

Has your child ever been hospitalized or had surgery? ○ Yes ○ No

If yes, please explain. _____

Does your child have any allergies to drugs, antibiotics, latex, dyes, etc.? ○ Yes ○ No

If yes, please explain. _____

May we request the release of your child's medical records for our reference? ○ Yes ○ No

Has the child ever had any history or difficulty with any of the following? (Please check all that apply.)

○ AIDS/HIV	○ Cerebral Palsy	○ Fainting	○ Mastoid
○ Anemia	○ Chronic sinus	○ Hearing Problems	○ Mononucleosis
○ Asthma	○ Convulsions	○ Heart	○ Pregnancy (teen)
○ Autism	○ Diabetes	○ Hepatitis	○ Rheumatic Fever
○ Blood/bleeding disorders	○ Ear aches/infections	○ Kidney	○ Tobacco use
○ Bone/joint replacement	○ Epilepsy/seizures	○ Liver	○ Thyroid
○ Cancer			

○ Other _____

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should know. _____

_____

Consent for Services

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia (laughing gas) and use of proper and acceptable methods to complete same. I accept responsibility for payment of services rendered for the patient referenced on this form. I understand that I will be informed of any treatment (other than routine cleanings, fluoride treatments, x-rays and examinations) before that treatment is performed.

Parent/Guardian Signature _____ Date _____