Smiles By Design

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date: ________________Child's Name: _____________________[ ] Male [ ] Female
Nickname: ___________________Child's Birthday: ___/___/___ Child's Age:________
School:______________________ Grade:______
Child's Home Phone: (___)___-_______SS#:________________
Child's Home Address:____

Who Is Accompanying The Child Today?
Name:_________________________________Relation:______________________________
Do you have legal custody of this child? [ ] Yes [ ] No
Whom may we thank for referring you:____
Other family members seen by us:____
Previous/Present Dentist:_____________________________Last visit date:_______________
Parent's Marital Status: [ ] Single [ ] Married [ ] Widowed [ ] Divorced [ ] Separated

[ ] Mother's Information [ ] Step Mother [ ] Guardian

Name:_______________________________Birthdate:___/___/___ SS#:___________________
Wk#:(____)____-_______Ext:____ Home Number: (___)____-________Cell:(___)____-____
Employer:_______________________________________

[ ] Father's Information [ ] Step Father [ ] Guardian

Name:_______________________________Birthdate:___/___/___ SS#:___________________
Wk#:(____)____-_______Ext:____ Home Number: (___)____-________Cell:(___)____-____
Employer:_______________________________________

Person Responsible For Account

Name:__________________________Relation:__________________Wk#: (____)____-_____
SS#:________________________Home #: (____)____-______
Billing Address:____

Primary Dental Insurance
Insurance Co. Name:____
Insurance Co. Address:____
Insurance Co. Phone: (____)_____-______ Group # (plan, local or policy#)_________________
Policy Owner's Name:________________________Relation to patient:____________________
Policy Owner's Birthdate: ____/____/_____ Policy Owner's Employer:____________________

Secondary Dental Insurance
Insurance Co. Name:____
Insurance Co. Address:____
Insurance Co. Phone: (____)_____-______ Group # (plan, local or policy#)_________________
Policy Owner's Name:________________________Relation to patient:____________________
Policy Owner's Birthdate: ____/____/_____ Policy Owner's Employer:____________________

Has the Child ever had the following medical problems?
(please circle one)

Y	N	Abnormal Bleeding	Y	N	Handicaps/Disabilities
Y	N	Allergies to any drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Murmur
Y	N	Any Operations	Y	N	Hemophilia
Y	N	Asthma	Y	N	Hepatitis
Y	N	Cancer	Y	N	HIV+/AIDS
Y	N	Congenital Heart Defect	Y	N	Kidney / Liver Problems
Y	N	Convulsions / Epilepsy	Y	N	Rheumatic /Scarlet Fever
Y	N	Diabetes	Y	N	Tuberculosis (TB)

Please discuss any medical problems that the child has had:____________________________
____

Why did you bring the child to the dentist today? ____________________________________

Has the child ever had a serious/difficult problem associated with previous dental work?
[ ] Yes [ ] No
If yes please explain: ____
____
Does the child brush his / her teeth daily? [ ] Yes [ ] No
Floss his / her teeth daily? [ ] Yes [ ] No
Child's Physician:______________________Phone: (_____)____-_____ Last Visit Date:________
Is the child currently under the care of physician? [ ] Yes [ ] No
Please list all drugs that the child is currently taking:__________________________________
____

Please list all drugs/materials that the child is allergic to:_____________________________
____

Does the child have the following habits?
(please circle one)

Y	N	Lip Sucking / Biting
Y	N	Nail Biting
Y	N	Nursing Bottle Habits
Y	N	Thumb / Finger Sucking

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA and ADA.

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 it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

(Signature of parent or guardian) ________________________________ Date_________

Doctors Signature ____ Date _________