Bright Smiles Kids Dentistry

New Patient Information

About Your Child

Child's Name: _____

Nickname: _____

Gender: Male Female Date of Birth: _____

Address: _____

City: _____ State: _____

Zip: _____

How did you find out about us? _____

School/Daycare does patient attend? _____

Special Interests: _____

List any sports or hobbies: _____

Emergency Contact

Name: _____

Address: _____

City _____ State _____ Zip _____

Phone _____

Relationship _____

Responsible Party(Insurance Policy Holder)

Parent/Guardian Full Name: _____

Address: _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Cell Phone:_____

Email Address _____

Dental Insurance: ❑ Yes ❑ No

Insurance Company _____

ID# or SS# _____Group#_____

Insurance Company Phone _____

Employer of policy holder _____

Parent's Marital Status:
❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Single

If there is a secondary insurance:

Secondary Party: _____

Address: _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Email Address _____

Dental Insurance: ❑ Yes ❑ No

_____

Insurance Company _____

ID# or SS#_____ Group#_____

Insurance Company Phone _____

Employer of policy holder _____

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 _____ (child's name). 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.

_____

SIGNED (parent or legal guardian) **DATE**

*Please fill out the back**

Bright Smiles
Kids Dentistry

Dental History

❑ Yes ❑ No Is this your child's first visit to the dentist?
What was done? _____

❑ Yes ❑ No Do you expect your child to be a cooperative patient? If no, please explain:_____
_____

❑ Yes ❑ No Does your child take fluoride supplements?

❑ Yes ❑ No Has your child bumped any teeth?
If yes, explain_____

❑ Yes ❑ No Has your child had a history of pain, popping or clicking of the jaws?

❑ Yes ❑ No Does your child have a toothache?

Does your child have any of the following habits?

❑ Thumb Sucking How Long?_____
❑ Finger Habit How Long?_____
❑ Pacifier How Long?_____

How often does your child brush? _____
Is tooth brushing supervised? ❑ Yes ❑ No
By whom?_____
Is dental floss used? ❑ Yes ❑ No

Medical Information

Child's Physician:_____
Address: _____
Phone Number: _____
Does your child require antibiotics before dental procedures?
❑ Yes ❑ No

Is your child in good health? ❑ Yes ❑ No
If no, explain:_____
Is your child under the care of a physician or specialist (e.g. cardiologist) for anything other than routine care?

❑ Yes ❑ No If yes, explain: _____
_____

Has your child ever been hospitalized? ❑ Yes ❑ No
If so, explain: _____

Has your child had any surgeries? ❑Yes ❑ No
If so, explain: _____

Medical History

Please indicate if your child has had any of the following:

❑ Yes ❑ No Abnormal Bleeding Problems
❑ Yes ❑ No ADD/ADHD
❑ Yes ❑ No AIDS or HIV
❑ Yes ❑ No Anemia
❑ Yes ❑ No Anxiety
❑ Yes ❑ No Arthritis
❑ Yes ❑ No Asthma
❑ Yes ❑ No Autism
❑ Yes ❑ No Bladder Disorder
❑ Yes ❑ No Blood Disorder
❑ Yes ❑ No Cancer
❑ Yes ❑ No Cerebral Palsy
❑ Yes ❑ No Depression
❑ Yes ❑ No Diabetes
❑ Yes ❑ No Ear, Nose, Throat Problems
❑ Yes ❑ No Emotional/Behavior Problems
❑ Yes ❑ No Epilepsy or Seizure
❑ Yes ❑ No Fainting/Dizziness
❑ Yes ❑ No Frequent Headaches
❑ Yes ❑ No Heart Murmur
❑ Yes ❑ No Heart Problems
❑ Yes ❑ No Heavy Nightly Snoring
❑ Yes ❑ No Hepatitis
❑ Yes ❑ No Kidney Disorders
❑ Yes ❑ No Learning Delay/Disability
❑ Yes ❑ No Liver Disorders
❑ Yes ❑ No Premature Delivery
❑ Yes ❑ No Radiation Therapy
❑ Yes ❑ No Rheumatic Fever
❑ Yes ❑ No Sleep Apnea
❑ Yes ❑ No Thyroid (high / low)

Does your child have any DRUG allergies? ❑Yes ❑No
(e.g antibiotics, penicillin etc), please list:_____
_____

Does your child have ENVIRONMENTAL allergies?
❑ Yes ❑ No (e.g seasonal, red dye, latex etc), please list:
_____

Is your child taking any medications? ❑Yes ❑No
If yes, list: _____
_____

Please list any other condition your child has: _____
_____