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

Parent/Guardian Full Name: _____

Address: _____

City _____ State _____ Zip _____

SS# _____ Birthdate _____

Cell Phone: _____

Email Address _____

Dental Insurance: ❑ Yes ❑ No

Insurance Company _____

Group or Plan Number _____

Insurance Company Phone _____

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 _____

Group or Plan Number _____

Insurance Company Phone _____

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? If no, when was the last visit and what was done for your child?

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

_____

❑ Yes ❑ No Does your child take fluoride qT))gL,LxVqh

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

❑ Yes ❑ No Has your child had a history of headaches, 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

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❑ Yes ❑ No Allergies (Latex)
❑ Yes ❑ No Allergies (Other):_____

Medical History

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

❑ Yes ❑ No Abnormal Bleeding Problems

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❑ Yes ❑ No Anxiety

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❑ Yes ❑ No Depression

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❑ Yes ❑ No Heavy Nightly Snoring

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

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