SouthernSmiles pediatric dentistry

PATIENT INFORMATION AND HEALTH HISTORY FORM

(Please print and fill out both **FRONT** and **BACK**)

PATIENT INFORMATION

Patient's last name: First: MI:		Nickname/ Answers to:		
DOB:	Age:	Gender: ❑ M ❑ F	SSN #:	
Street Address:	City:	State:	ZIP Code:	
Mother/ Legal Guardian:	Employer:	Home/Cell #:	DOB:	SS#:
Father/ Legal Guardian:	Employer:	Home/Cell #:	DOB:	SS#:
How did you hear about us?	❑ Dr. ❑ Insurance Plan ❑ Website ❑ Family ❑ Friend ❑ Close to home/work ❑ Facebook ❑ Other			
Other family members seen here:		Email Address:		

INSURANCE INFORMATION

Does your child have Dental Insurance? ❑ Yes ❑ No		Insurance Company:		
Subscriber's Name:	Subscriber's SS #.:	Birth Date:	Group #:	Policy #:
Who has legal custody of child?		Person responsible for payment of account:		

MEDICAL HISTORY

Child's Physician:	Physician Phone:	Address:	Date of Last Medical Exam:
Is your child in good health? ❑ Yes ❑ No	Medications:	Drug Allergies:	Are your child's immunizations current? ❑ Yes ❑ No
Has your child ever had a health problem? ❑ Yes ❑ No If so, please explain:		Has your child ever been hospitalized or had general anesthesia or an emergency room visit? ❑ Yes ❑ No If so, please explain:	

PLEASE CHECK OFF IF YOUR CHILD HAS BEEN TREATED FOR ANY OF THE FOLLOWING:

_____ Abuse	_____ Congenital Birth Defects	_____ HPV	_____ Respiratory Issues	_____ Tuberculosis
_____ ADHD/ ADD	_____ Diabetes	_____ Jaundice	_____ Rheumatic Fever	_____ Tumors/ Growths
_____ AIDS/ HIV	_____ Endocrine/ Growth Issues	_____ Kidney Disease	_____ Seasonal Allergies	_____ Venereal Disease
_____ Anemia	_____ Epilepsy	_____ Latex Sensitivity	_____ Seizures	_____ Visually Impaired
_____ Asthma	_____ Food Allergies		_____ Shunts	
_____ Autism	_____ Frequent Infections	_____ Liver Disease/ GI Disease	_____ Sickle Cell Disease/ Trait	
_____ Blood Dyscrasias	_____ Hay Fever	_____ Mental Delays	_____ Snoring	
_____ Bone Disease	_____ Hearing Impaired	_____ Personality/ Social Disorders	_____ Speech Issues	
_____ Cancer	_____ Heart Disease	_____ Pregnant	_____ Spina Bifida	
_____ Cerebral Palsy	_____ Heart Murmur	_____ Radiation Treatment	_____ Tonsil/ Adenoid Issues	
_____ Cleft Lip/ Palate	_____ Hepatitis	_____ Recurrent Headaches	_____ Thyroid Disease	

DENTAL HISTORY

What is the reason for your child's visit today?

_____

Has your child ever been to the dentist? Date of last cleaning & x-rays? ❑ Yes ❑ No

Name of previous dentist/ office: _____

Has your child had local anesthetic? ❑ Yes ❑ No

Has your child experienced any unfavorable reaction from previous dental care? ❑ Yes ❑ No _____

Has your child been sedated for dental treatment? ❑ Yes ❑ No

_____

Have your child's teeth ever been injured? ❑ Yes ❑ No

_____

Have your child's teeth ever been injured? ❑ Yes ❑ No

_____

Does your child suck a finger, thumb or pacifier? ❑ Yes ❑ No

_____

Does your child go to bed with a bottle or sippy cup? ❑ Yes ❑ No

_____

Does your child smoke or chew tobacco? ❑ Yes ❑ No

_____

Please circle if your child is having problems with any of the following:

Cavities	Toothache	Sensitivity	Mouth Breathing	Trauma
Color of Teeth	Orthodontics	Jaw Sounds	Grinding	Gum Infections

FLUORIDE HISTORY

Is your home water supply fluoridated? ❑ Yes ❑ No

Do you use well water at your residence? ❑ Yes ❑ No

Does your child use fluoridated toothpaste? ❑ Yes ❑ No

Do you give your child any other forms of fluoride? ❑ Yes ❑ No

_____

Does your child participate in a school fluoride program? ❑ Yes ❑ No

LEGAL CONSENT

I give my permission for the following individuals to bring my child to the dentist:

1.) Name: _____
Relationship: _____
Phone #: _____

2.) Name: _____
Relationship: _____
Phone #: _____

3.) Name: _____
Relationship: _____
Phone #: _____

It is vital that all individuals that bring your child are aware that they <u>may not leave the facility</u> while your child is receiving treatment.

I am fully aware that the treatment and fees may change and payment is expected in full at the time of service. The treatment plan has been explained to me in the office. If we cannot reach you for permission, services may not be rendered if someone else brings your child for treatment.

CONSENT FOR DENTAL TREATMENT

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. The information listed on both sides of this form is complete and accurate to the best of my knowledge. I give consent for Dr. Raymond J. Tseng, associate dentists and staff to perform a dental examination, dental prophylaxis, fluoride treatment and take x-rays on my child. For the purposes of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational, or research purposes. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Southern Smiles Pediatric Dentistry to release any information required to process my claims.

_____ _____
Patient/Guardian signature *Date*

_____ _____
Doctor's Signature *Date*