



Welcome to KidsSmiles

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Child's Information

Today's Date: _____
Child's Name: _____
Last First MI
Child's Nickname: _____
Child's Age: _____ Male Female
Child's Birthdate: ____/____/____ S.S. # _____
School: _____ Grade: _____
Child's Home Phone Number: () _____
Child's Home Address: _____
Street Apt/Condo#
City State Zip Code

General Information

Who is accompanying the child today?
Name: _____ Relation: _____
Do you have custody of this child or are you the guardian?
 Yes No
Whom may we Thank for referring you: _____

Parent's Information

Who is responsible for the account? _____
Parent/Guardian's Name: _____
Parent's Marital Status Single Married Divorced
 Partnered Separated Widowed
Parent's Birthdate: ____/____/____ S.S. # _____
Home Phone Number: () _____
Cell Phone Number: () _____
Address (if different from child's): _____
Street Apt/Condo#
City State Zip Code
Email Address: _____
Employer: _____
Work Phone Number: () _____ Ext. _____

If you have dental insurance coverage for the child, please fill out below.

Insurance Company Name: _____
Policy Holder's Name: _____
Policy Holder's S.S. # _____

Emergency Contact Information

Name: _____ Phone Number: () _____
Address: _____
Street Apt/Condo# City State Zip Code

Release Information

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Parent's Signature Date

Parent Permission Policy

I give Kids Smiles permission to see my child(ren) in my absence. I understand that this consent consists of any treatment not limited to but including fillings, sealants, nerve treatments, and children's crowns/ caps. In order to complete treatment, topical and/or local anesthetic may be used, and my child's hands may need to be restrained.

As my child is a minor, I understand that someone over the age of 18 must accompany my child(ren) to the office and remain there for the duration of their appointment. I give consent for that person to make any decision concerning my child's treatment.

I understand that a parent or legal guardian must be present at their initial and six-month visits in order to present and update treatment plans for my child to be seen.

I also consent to my child's name and birth date being placed on the outside of their chart. I understand that Kids Smiles will keep this information as private as possible.

Parent's Signature Date

Dental & Medical History

Tell us why you brought the child to the dentist today: _____

Has the child ever taken any diet pills such as Phen-fen (also known as Redux or Pondimin)? Yes No

If so, when? _____

Is the child currently in pain? Yes No

Does the child need antibiotics before dental treatment? Yes No

If yes, why? _____

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Does the child floss his/her teeth daily? Yes No

Is the child currently under the care of a physician? Yes No

Child's Physician: _____

Phone Number: () _____
Date of last visit

Previous/Present Dentist: _____

Phone Number: () _____
Date of last visit

How would you describe the child's current physical health? Good Fair Poor

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking:

Aside from the items below, list all other drugs/things that the child is allergic to:

Latex Yes No

Plastic Yes No

Nickel/Metals Yes No

Nut/Tree nut/Peanut Yes No

Dental & Medical History Continued...

Has the child experienced the following medical problems?

ADD/ADHD Yes No Abnormal Bleeding / Hemophilia Yes No

AIDS/HIV+ Yes No Artificial Bones / Joints / Valves Yes No

Anemia Yes No Congenital Heart Defect Yes No

Asthma Yes No Handicaps or Disabilities Yes No

Autism Yes No Developmental Issues Yes No

Cancer Yes No Kidney or Liver problems Yes No

Chicken Pox Yes No Mitral Valve Prolapse Yes No

Convulsions Yes No High Blood Pressure Yes No

Diabetes Yes No Low Blood Pressure Yes No

Epilepsy Yes No Are child's immunizations current? Yes No

Heart Murmur Yes No Had any hospital stays / operations Yes No *If yes, when & why?*

Hepatitis Yes No

Hives Yes No

Lupus Yes No

Measles Yes No

Mononucleosis Yes No

Prosthetics Yes No

Rheumatic Fever Yes No

Scarlet Fever Yes No

Sickle Cell Disease Yes No

Skin Rash Yes No

Tuberculosis (TB) Yes No

Born Prematurely Yes No

If yes, at what week? _____ Yes No

Did the child experience any of the following? (check all that apply)

Breast Fed Nursing Bottle Habits

Chewing on Objects Speech Problems

Clenching / Grinding Teeth Thumb / Finger Sucking

Lip Sucking / Biting Tongue / Cheek Biting

Mouth Breather Tongue Thrust

Nail Biting Used a Pacifier

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

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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.

Parent's Signature

Date

OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent or guardian and patient named herein.

Dentist's Signature

Date

Dentist's Comments: _____

Clearance required? Yes No

Medical History Update

Has there been any change in the child's health status since their last visit? If so, please explain. Be sure to include new medication(s) or discontinued medication(s).

Signature of Parent or Guardian

Date

Signature of Parent or Guardian

Date

Has there been any change in the child's health status since their last visit? If so, please explain. Be sure to include new medication(s) or discontinued medication(s).

Signature of Parent or Guardian

Date

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Date