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Smith's little smiles
PEDIATRIC DENTISTRY

Marita Smith, DDS
Board Certified
Pediatric Dentistry

We are thrilled to welcome you and your family and look forward to working with you to maintain your child's oral health. Please fill out this form as completely as possible. If you have any questions, we will be happy to help.

Tell Us About Your Child

Child's Name _____ ❑M ❑F
Last First MI
Nickname_____Child's Birthdate ____/____/____ Age_____
Address_____
City _____ State _____ Zip_____
Does Your Child Play Sports? ❑ Yes ❑ No If Yes, What Sports_____
How did you hear about our Office? (please list name)
❑Pediatrician/Other Dentist_____ ❑Friend _____
❑School/Church/Synagogue_____ ❑Google ❑Yelp ❑Local Newspaper
❑NY Metro Parents Magazine ❑NY Metro Parents Website ❑Other _____

Mother's Information

Name _____ DOB ___/___/____
Occupation _____SS# ____-____-_____
Employer (name/address)_____
_____
Cell Phone _____ Home Phone _____
Work Phone _____ Email _____
Preferred Method of Contact:
❑Text Message ❑Email ❑Cell Phone ❑Work Phone ❑Home Phone

Father's Information

Name _____ DOB ___/___/____
Occupation _____SS# ____-____-_____
Employer (name/address)_____
_____
Cell Phone _____Home Phone_____
Work Phone _____ Email _____
Preferred Method of Contact:
❑Text Message ❑Email ❑Cell Phone ❑Work Phone ❑Home Phone

Who is accompanying the child today?
Name _____ Relationship _____
Authorized Nanny/Sitter/Au Pair _____

In the event that I am unable to bring my child in for an appointment the following individuals have my permission to accompany my child and make any necessary decisions for my child's care. This includes consenting to any necessary treatment plan changes.

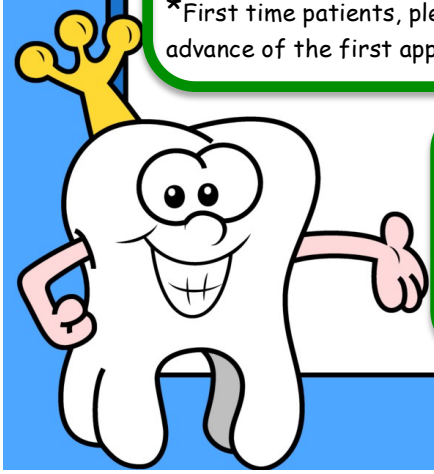
Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

The legal guardian must accompany their child/children for the first appointment.

Insurance/Financial Information

Name of Dental Insurance Company_____
Telephone # of Insurance Company _____
Policy Holder ID # _____ Group # _____
*First time patients, please bring your dental insurance card to the office or email copies of both sides in advance of the first appointment.

Policy Owner's Name_____
Relationship to Patient_____
Policy Owner's Birthdate_____
Social Security #_____
Policy Owner's Employer_____



Health History

Your Child's health is ❑Excellent ❑Fair ❑Poor

Child's Physician _____Phone # _____

Date of last physical exam ___/___/____

Has your child ever been hospitalized overnight? ❑Yes ❑No

When? _____ Reason for hospitalization_____

Vaccinations up to date? ❑Yes ❑No

History of Surgery? ❑Yes ❑No Type of Surgery_____

Does your child have any allergies to food? ❑Yes ❑No

If yes, please list

_____

_____

Does your child have any allergies to medicine? ❑Yes ❑No

If yes, please list

_____

_____

Has your child ever had any of the following conditions?

❑Asthma	❑Autism Spectrum Disorder	❑ADHD
❑Heart Murmur	❑Congenital Heart Defect	❑Arrhythmia
❑Epilepsy/Seizures	❑Artificial Heart Valve	❑Cancer/Tumors
❑Leukemia	❑Lymphoma	❑Sickle Cell
❑Artificial bones/Joints	❑Recurrent Ear Infections	❑Cleft Lip/Palate
❑Developmental Delay	❑Birth Defects	❑Glaucoma
❑Thyroid Function Issue	❑Cerebral Palsy	❑HIV/AIDS
❑Blood Transfusion	❑Abnormal Bleeding	❑Hemophilia
❑Endocrine Function	❑Issue Fainting/Dizziness	❑Lung Disease
❑Crohn's Disease	❑High/Low Blood Pressure	❑Hearing Loss
❑Ulcerative Colitis	❑Liver/ Hepatitis	❑G6PD
❑Gluten/Celiac Disease	❑Diabetes	❑Anemia
❑Kidney Disease	❑Jaundice	❑Tuberculosis

❑Other not listed_____

Please List ALL medications your child takes, their dosages and frequency

_____

_____

_____

_____

_____

Dental History

Reason for Today's Visit _____

Is this your child's first visit to the dentist? ❑Yes ❑No

If not, who was the previous dentist _____Phone #_____

When was your child's last exam? ___/___/____

When were x-rays taken? ___/___/____

If x-rays were taken, please ask previous office to email records to drsmith@smithslittlesmiles.com

Has your child had any previous dental injury? ❑Yes ❑No

If yes, when? ___/___/____

Does your child require pre-medication prior to dental treatment? ❑Yes ❑No

Has your child had a history of the following and if so when did they stop:

❑Bedtime Bottle	❑Fluoride Vitamins	❑Pacifier	❑Breast Feeding
❑Iron Supplements	❑Teeth Grinding	❑Bottled Water	❑Mouth Breathing
❑Snoring	❑Thumb Sucking	❑Finger Sucking	❑Fingernail Biting
❑Sleep Apnea	❑ TMJ	❑Other Habits_____	

Age Stopped _____

What Kind of multivitamin does your child use, if any?

❑Chewable ❑Liquid ❑Drops ❑Gummy ❑None

Does your child take a fluoride supplement prescribed by a pediatrician or a previous dentist? ❑Yes ❑No

Do you brush your child's teeth or do they brush independently? _____

Does your child use: ❑Floss/Flossers ❑Fluoride Rinse (ie ACT)

Has your child had any previous negative dental experiences? ❑Yes ❑No

If yes, please explain_____

_____

Please list any additional questions or concerns you may have_____

_____

_____

HIPAA Privacy Practices Notification

I, the undersigned parent/legal guardian of_____, have been issued the HIPAA Notice of Privacy Practices. I fully understand that the Practice is required by law to maintain the privacy of my child's medical and health information. I acknowledge that the Practice will use and disclose my child's health information for the purposes of treating my child, obtaining payment for services rendered to my child and conducting health care operations.

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk. Furthermore, I understand that it is my responsibility to inform this dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners as necessary. I hereby authorize the Dr. Marita Smith or any other doctor employed by Smith's Little Smiles to perform the examination and after explanation, any and all treatment for the above named child including radiographs if indicated and consent to such methods, drugs and agents that may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that, as a condition of my child's treatment by this office, financial arrangements must be made in advance.

Parent/Guardian's Signature _____

Parent/Guardian Name Printed _____

Date _____