Welcome to

Smile Shapers

Family and Cosmetic Dentistry

Child Medical History

ABOUT YOUR CHILD

Child's Name:

Nickname: ☐ Male ☐ Female

Date of Birth: Age: SSN:

Home Address:

Home Phone: ( )

School: Grade:

Siblings Names:

DENTAL HISTORY

What is the primary reason for your visit today?

Who referred you to our office?

Date of last dental visit?

Name of dentist:

	YES	NO
Has child had trouble from previous dental care?	☐	☐
Does child have pain in her/her jaw joint (TMJ)?	☐	☐
Has child ever had Novocaine or other local anesthetic?	☐	☐
Is child taking fluoride supplements?	☐	☐
Does child have bad breath?	☐	☐
Does child have frequent sores on lips or mouth?	☐	☐
Is child experiencing any pain or sensitivity in his/her mouth or teeth?	☐	☐
Are there any other problems not covered in this section that you would like to discuss? If so, please specify:	☐	☐

Does child have any of the following habits?	YES	NO
Lip sucking / biting	☐	☐
Nail biting	☐	☐
Breathing through mouth	☐	☐
Clenching / grinding teeth	☐	☐
Thumb / finger sucking	☐	☐
Used pacifier	☐	☐
Tongue / cheek biting	☐	☐
Tongue thrust	☐	☐
Breast fed	☐	☐
Frequent bottle use or sleeps with bottle at night	☐	☐

PARENT INFORMATION

Your Name:

Relationship: ☐ Mother ☐ Father ☐ Other:

If other, please specify:

Occupation: Work Phone: ( )

Home Phone: ( ) Cell Phone: ( )

Alternate Contact:

Relationship: ☐ Mother ☐ Father ☐ Other:

Occupation: Work Phone: ( )

Home Phone: ( ) Cell Phone: ( )

Emergency Contact:

Relationship to Child:

Phone: ( ) Cell Phone: ( )

DENTAL INSURANCE INFORMATION

PRIMARY

Insured's Name:

Date of Birth: SSN:

Employer:

Relationship to subscriber:

Insurance Company:

SECONDARY

Insured's Name:

Date of Birth: SSN:

Employer:

Relationship to subscriber:

Insurance Company:

MEDICAL INFORMATION

Child's Physician:

Physician Phone: ( )

Physician Fax: ( )

Physician Address:

Date of Last Exam:

Continued on reverse. Please complete both sides.

MEDICAL HISTORY

Certain illnesses and drugs may have a direct effect on the oral cavity and, consequently, dental treatment. In our endeavor to render appropriate uncompromising health care, it is necessary that **Smile Shapers** has the following information.

Does your child have, or has your child ever, had the following? If so, please indicate "YES" and circle the illness:

	YES	NO
1. Allergies – Medications (i.e., penicillin, etc.) – Food, dust, etc. Specify: _____	☐	☐
2. Anemia or blood disorders?	☐	☐
3. Any abnormal or prolonged bleeding or easily bruised?	☐	☐
4. Asthma or other respiratory ailment?	☐	☐
5. Cancer?	☐	☐
6. Congenital heart disease or heart murmur?	☐	☐
7. Convulsions, seizures, fainting or epilepsy?	☐	☐
8. Diabetes or blood sugar problems?	☐	☐
9. High/low blood pressure?	☐	☐
10. Immunioompromised HIV AIDS?	☐	☐
11. Kidney or bladder problems?	☐	☐
12. Liver or thyroid problems?	☐	☐
13. Rheumatic fever or rheumatic heart disease?	☐	☐
14. Tuberculosis or pneumonia?	☐	☐
15. Speech, learning or hearing disorders?	☐	☐
16. Hospitalized since birth? Specify: _____	☐	☐
17. Presently taking any medications? Specify: _____	☐	☐
18. Childhood illnesses? Specify: _____	☐	☐
19. Any medical conditions/problems not stated above that should be brought to our attention? Specify: _____	☐	☐

ADDITIONAL INFORMATION

Please include any additional medical or dental conditions or concerns not listed above that we should know about:

PARENT OR GUARDIAN SIGNATURE	DATE	DOCTOR SIGNATURE	DATE

I hereby certify that the information provided on this form is true and correct in its entirety. Since _____ (NAME OF CHILD) is a minor patient, signed permission from a parent of guardian is required before any necessary dental treatment can be initiated. By signing this form, I hereby grant such permission.

I also acknowledge my responsibility for any professional fees incurred for dental services provided to the child.

I authorize **Smile Shapers** to release my child's dental records to the insurance carrier(s) named on the reverse side for insurance purposes.

Signed X _____ **Date** _____

This section is for Dentist use only.

DOCTOR UPDATES

DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X
	X		X		X
	X		X		X
	X		X		X

DOCTOR COMMENTS