Welcome to Smile Starters Pediatric Dentistry!

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We are thrilled to welcome you and your family. Please fill out this form as completely as possible. If you have any questions, we are happy to help.

Patient's Information and Health History

Child's Full Name______________________________Nickname ______________________________

Date of Birth ____________ Age________Sex: ☐ *M* ☐ *F* Grade________Patient lives with: ☐ Mother ☐ Father ☐ Both ☐ Other

Name(s) and age(s) of other children in family ______________________________
Name(s) of other children seen in this office ______________________________
Whom may we thank or referring you to our office? ______________________________
Is this your child's first visit? *Yes* *No* If no, name of former dentist ______________________________
Who is your family dentist? ______________________________

Parents' Marital Status ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

Guarantor (Person responsible for payment of dental services)

Guarantor______________________________
Relationship ☐ *Mother* ☐ *Father* ☐ *Guardian* ☐ *Stepmother* ☐ *Stepfather*
Date of Birth________________SS # ____________________
Address______________________________
City____________________State____________Zip ____________
Primary (Daytime) Phone ______________________________
Secondary (Cell) Phone ______________________________
Email______________________________
Drivers License #______________________State __________

Secondary Contact

Name______________________________
Relationship ☐ *Mother* ☐ *Father* ☐ *Guardian* ☐ *Stepmother* ☐ *Stepfather*
Date of Birth________________SS # ____________________
Address______________________________
City____________________State____________Zip ____________
Primary (Daytime) Phone ______________________________
Secondary (Cell) Phone ______________________________
Email______________________________
Drivers License #______________________State __________

Insurance Information - **Please give all your insurance cards to the receptionist.** *If no insurance, check here:* ☐ *Self Pay*

Primary Insurance______________________________Relationship to Patient ______________________________
Employer______________________Group #____________________Member ID ______________________________

Secondary Insurance______________________________Relationship to Patient ______________________________
Employer______________________Group #____________________Member ID ______________________________

Pharmacy Information

Name______________________________Phone ______________________________
Address______________________________

Medical History

Child's Physician________________________________ Phone ________________

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

If yes, please explain: ________________________________

Please describe your child's current physical health. ☐ *Good* ☐ *Fair* ☐ *Poor*

Are all immunizations up-to-date? ☐ *Yes* ☐ *No*

Does your child have any allergies to latex/medications (Penicillin) /food/other? ☐ *Yes* ☐ *No*

If yes, please list: ________________________________

Has your child been diagnosed with or treated for any of the following:

- ☐ *AIDS/HIV*
- ☐ *Anemia*
- ☐ *Any Hospital Stays/Surgeries*
- ☐ *Asthma*
- ☐ *ADHD*
- ☐ *Autism*
- ☐ *Cerebral Palsy*
- ☐ *Cleft Lip/Palate*
- ☐ *Diabetes*
- ☐ *Epilepsy/Seizures*
- ☐ *Hearing/Speech Issues*
- ☐ *Heart Disease*
- ☐ *Heart Murmur*
- ☐ *Hemophilia Type ____*
- ☐ *Hepatitis Type _*
- ☐ *High / Low Blood Pressure*
- ☐ *Kidney Problems*
- ☐ *Learning Disabilities*
- ☐ *Liver Problems*
- ☐ *Sinus Problems/Sleep Apnea*
- ☐ *Tuberculosis (TB)*

If yes to any of the above or other not listed, please explain ________________________________

Please list all medications your child is taking ________________________________

Dental History

What is the **primary** reason for your visit today? ________________________________

Does your child currently have problems with any of the following?

- ☐ *Cavities*
- ☐ *Gum Infection*
- ☐ *Toothache*
- ☐ *Tongue Habit*
- ☐ *Oral habits*
- ☐ *Bites fingernails*
- ☐ *Alignment*
- ☐ *Speech*
- ☐ *Trauma*
- ☐ *Tooth color*
- ☐ *Sensitive Teeth*
- ☐ *Other ________________*

Has your child experienced problems with previous dental work? ☐ *Y* ☐ *N*

Please explain ________________________________

Does your child take a fluoride multivitamin? ☐ *Y* ☐ *N* If yes, what kind? ________________

Does your child brush his/her teeth daily with fluoride toothpaste? ☐ *Y* ☐ *N*

Does your child floss his/her teeth daily? ☐ *Y* ☐ *N*

Was your child bottle/breast-fed? ☐ *Y* ☐ *N* Age stopped? ________________

Does your child have oral habits? ☐ *Y* ☐ *N* If yes, describe ________________

Does your have speech, occupational, or physical therapy? ☐ *Y* ☐ *N*

Does your child play any sports? ☐ *Y* ☐ *N* If yes, what sports? ________________

Previous Dentist________________________________ Date of last visit ________________

Why did you leave your last dentist? ________________________________

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 be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize Dr. Georgescu and Dr. Calamia to perform necessary dental procedures including, but not limited to, the use of nitrous oxide, local anesthesia and take any necessary radiographs to diagnose and/or treat my child's dental needs. I also authorize Dr. Georgescu and Dr. Calamia to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payer and/or other healthcare practitioners.

Signature of Patient (or Parent/Guardian if minor)________________________ Relationship________________

Please Print Name________________________________ Date ________________