WYNNEWOOD SMILES FAMILY AND COSMETIC DENTISTRY

ABOUT YOUR CHILD

Child's Name: ______________________________
Last Name First M.I.

Nickname: ________________ ☐ Male ☐ Female

Date of Birth: ________ Age: ____ SSN: ______________

Home Address: ______________________________

____
City State Zip Code

Home Phone: ( ) ________________

School: ______________________ Grade: __________

Sibling's Name: ______________________________

PARENT INFORMATION

Mother's Name: ______________________________

Employer: ______________________________

Work Phone: ______________________________

Father's Name: ______________________________

Employer: ______________________________

Work Phone: ______________________________

Emergency Contact: ______________________________

Phone/Cell: ______________________________

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

Insured's Name: ______________________________

Date of Birth: ______________________________

Social Security Number: ______________________________

Employer: ______________________________

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group Plan/Policy No: ______________________________

DENTAL INSURANCE INFORMATION

SECONDARY CARRIER

Insured's Name: ______________________________

Date of Birth: ______________________________

Social Security Number: ______________________________

Employer: ______________________________

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

Insurance Co. Phone #: ______________________________

Group Plan/Policy No: ______________________________

DENTAL HISTORY

Please check "yes" or "no" to the questions below:	**Yes**	**No**
Are your child's immunizations current?	☐	☐
Has your child had trouble from previous dental care?	☐	☐
Does your child have pain in his/her jaw joint (TMJ)?	☐	☐
Has any type of local anesthetic ever been administered to your child?	☐	☐
Does your child have bad breath?	☐	☐
Does your child have frequent sores on lips or mouth?	☐	☐
Is your child experiencing any pain or sensitivity in his/her mouth or teeth?	☐	☐

Does your 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 / sleeps with bottle at night	☐	☐

Is there any other problem not covered in this section that you would like to discuss? ☐ Yes ☐ No

If yes, please specify: ______________________________

____

What is the primary reason for your visit today? ______________________________

Who referred you to our office? ______________________________

Date of last dental visit? ______________________ Name of dentist? ______________________

PEDIATRIC DENTAL & MEDICAL HEALTH HISTORY

PATIENT NAME: ______________________________ **ACCOUNT NO.** ____________________

MEDICAL INFORMATION

Please provide us with the name of your child's physician: ______________________________
Physician's address: ______________________________
Phone Number: ______________________ Date of Last Exam: ______________________

MEDICAL HISTORY

MEDICAL HISTORY - Certain illnesses and drugs may have direct effect on the oral cavity and consequently, dental treatment. In our endeavor to render appropriate uncompromising health care, it is necessary to have the following information:

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD THE FOLLOWING? If yes, please indicate "YES" and circle illness:

	YES	NO
1. Allergies: - Medication (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. Immunocompromised 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 condition/problems not stated above that should be brought to our attention? ______________	☐	☐

Parent or Guardian Signature	Date:	Doctor's Signature	Date:
X		**X**	

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 or guardian is required before any necessary dental treatment can be initiated. By signing this form, I hereby grant such permission. I acknowledge my responsibility for any professional fees incurred for dental services provided to my child. I authorize Wynnewood Smiles Family and Cosmetic Dentistry to release my child's dental records to the insurance carrier(s) named in this document for insurance purposes:

Signed: X ______________________________ Date: ______________________

This section is for Dentist use only.

DOCTOR UPDATES

DATE:	DOCTOR Initials	Date:	DATE:	DOCTOR Initials	Date:	DATE:	DOCTOR Initials	Date:
	X			X			X	
DATE:	DOCTOR Initials	Date:	DATE:	DOCTOR Initials	Date:	DATE:	DOCTOR Initials	Date:
	X			X			X	

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DOCTOR UPDATES