We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in creating your beautiful smile!

Patient Information

Name: ______________________________________ Date of Birth: _____/_____/_____Age:____

Nickname: __________________Male: _____Female: _____Social Security: _______-_______-_______

Address: ______________________________City: _________________State: _____Zip: __________

Home Telephone: ______-_______-_______ Whom May We Thank For Your Referral: _______________

Patient's Dentist:____________________________________ Last Check-up/Cleaning: ____/____/____

Responsible Party Information

Mother/Guardian Name: ____________________________________Date of Birth: _____/_____/_____

Social Security: ______-_______-_______ Employer: ____

Address: _______________________________City: ________________State: _____Zip: __________

Home Telephone: ______-_______-_______ Work: _____-______-______ Cell: ______-_______-______

Father/Guardian Name: _____________________________________ Date of Birth: ____/_____/_____

Social Security: ______-_______-_______ Employer: ____

Address: _______________________________City: ________________State: _____Zip: __________

Home Telephone: ______-_______-_______ Work: _____-______-______ Cell: ______-_______-______

Primary Insurance Coverage

Primary Insured Name: ___________________________________ Date of Birth: _____/_____/______

Relationship to Patient: _______________________________Social Security: ______-______-______

Employer: _______________________________ Address: __________________________________

Name of Insurance: _________________________________Group Number:____________________

Address: ____ Telephone: ______-______-______

Secondary Insurance Coverage

Secondary Insured Name: __________________________________Date of Birth: _____/_____/______

Relationship of Patient: ______________________________Social Security: ______-_______-_______

Employer: ______________________________ Address: ___________________________________

Name of Insurance: _________________________________ Group Number: ____________________

Address: ____ Telephone: ______-______-______

Dental History

Reason for Dental/Orthodontic Examination: ____

Has Patient Had Previous Dental/Orthodontic Treatment/Consultation? _________________________

Y N Speech Problems
Y N Lip Biting
Y N Bleeding Gums
Y N Thumb Sucking
Y N Finger Biting
Y N Grinding Teeth
Y N Have Tonsils Been Removed
Y N Food Collects Between Teeth
Y N Clicking/Popping of the Jaw

Medical History

Physician's Name: ____Telephone:_____-_____-_____

Address: __________________________City: ________________ State: ______ Zip: __________

Date of last physical exam: ______/_____/______ Results:____________________________________

Is patient under care of physician now Y N If yes, why _________________________________

Has patient ever been hospitalized Y N If yes, why _________________________________

Has patient ever had surgery Y N If yes, why _________________________________

(Women) Are you pregnant Y N Nursing Y N Taking birth control pills Y N

Has Patient reached Puberty Y N Girl started menstruation Y N Boy-has voice changed Y N

Has the Patient had any of the following:

Y N A.I.D.S/H.I.V
Y N Anemia
Y N Asthma
Y N Bladder Problems
Y N Blood Transfusion
Y N Bruise Easily
Y N Cancer
Y N Cerebral Palsy
Y N Cleft Lip /Palate
Y N Convulsions
Y N Developmental
Y N Diabetes
Y N Epilepsy
Y N Fainting
Y N Hay Fever
Y N Hearing Problems
Y N Heart Problems
Y N Hepatitis
Y N Jaundice
Y N Kidney Disease
Y N Liver Disease
Y N Mental Retardation
Y N Rheumatic Fever
Y N Sinus Problems
Y N Thyroid Disease
Y N Tuberculosis
Y N Premature
Y N Phen Phen

Other: ____

Is Patient taking any Medication? _______ If yes, list names and purpose: _______________________

Are You Allergic to or had a reaction to any of the following? Please Circle

Aspirin Barbiturates Sedatives Metal Local Anesthetics None Known

Amoxicillin Sleeping Pills Sulfa Drugs Latex Any Others: _____________________

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental/orthodontic staff to perform the necessary dental/orthodontic services for my/my child. I certify that the patient is covered by insurance with: ____________________. I assign directly to Smiles 4 Kids, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that responsibility for payment for dental/orthodontic services provided in the office for me/my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize Smiles 4 Kids, to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any changes in my/my child's insurance coverage.

Signature: ____Date: _____/______/______