KIDDSMILES
PEDIATRIC DENTISTRY

Registration & Health History Form Today's Date: _____/_____ /_____

Welcome! To our dental office, where we provide individualized care for infants, toddlers, children and teens! Our focus is on prevention and early management of dental disease. We are honored that you have entrusted your child's care to us. We take great pride in providing a comfortable experience for children and their families. Should you have any special request, please inform us and we will do our best to accommodate you.

How did you hear about? ☐Google + ☐Facebook ☐Twitter ☐Internet ☐Newspaper ☐Insurance Search
Other:_____

Tell us about your child:

Name: _____

Goes by: _____ ☐ Male ☐ Female

Birth date: _____/_____ /_____ Age: _____

School: _____ Grade: _____

Home address: _____

City:_____State:_____Zip:_____

Home Phone: (_____) _____

Parent one: ☐ Mom ☐ Dad ☐ Guardian

Name: _____

DOB: _____ /_____ /_____

Best way to contact: (_____)_____☐ H ☐ W ☐ C

Email: _____ _____

SS#:_____/_____ /_____

Dental Insurance: Primary

Insurance company name:_____
Policy owner's name: _____
Policy owner's birth date: _____
SSN#:_____ /_____ /_____
Member number: _____
Group number: _____
Relationship to patient: _____
Address:_____
Insurance number: (___)_____

Who is accompanying your child today?
Name: _____

Relationship: _____

Do you have legal custody of your child? ☐Yes ☐No

Is there anyone you would like to designate to bring your child for dental appointments other than mom/dad? If yes, please list:
Name & relationship: _____

Name & Relationship: _____

Parent two: ☐ Mom ☐ Dad ☐ Guardian

Name: _____

DOB: _____ /_____ /_____

Best way to contact: (_____)_____☐ H ☐ W ☐ C

Email: _____

SS#:_____/_____ /_____

Dental Insurance: Secondary

Insurance company name:_____
Policy owner's name: _____
Policy owner's birth date: _____
SSN#:_____ /_____ /_____
Member number:_____
Group number: _____
Relationship to patient: _____
Address:_____
Insurance number: (___)_____

Dental History:

Is this your child's first visit to a dentist ☐YES ☐NO
If no, how long since the last visit? _____
Previous dentist's name:_____
Any X-rays taken at previous dental visit? ☐YES ☐NO
Any injuries to the teeth, face, or mouth? ☐YES ☐NO
If yes, please explain: _____
Family History of Dental Problems? ☐YES ☐NO
If yes, please explain:_____
Why did you bring your child to the dentist today?_____
Do you have any dental concerns or questions?_____
Have previous dental visits been positive or negative? Please explain:_____

Do any of the following apply to your child?

Y N Frequent snacking
Y N Sleeping with a bottle
Y N Tooth grinding
Y N Sippy cup use
Y N Breast-feeding
Y N Thumb sucking
Y N Pacifier use

Cups per Day of: _____ **Milk** _____ **Juice** _____ **Soda**

Cups per Night of: _____ **Milk** _____ **Juice** _____ **Soda**

Dental Care: at home

Brush his own teeth? ☐ YES ☐ NO
If yes, how often? ____ (X) a day
Do you Brush you child's teeth? ☐ YES ☐ NO
Difficulty brushing his or her teeth? ☐ YES ☐ NO
Does your child floss daily? ☐ YES ☐ NO
Do you floss your child's teeth ☐ YES ☐ NO
Is your child able to spit? ☐ YES ☐ NO
Is your child taking fluoride supplements? ☐ YES ☐ NO
Does your child use fluoride toothpaste ☐ YES ☐ NO
Does your child use xylitol products ☐ YES ☐ NO

Medical history:

Has your child ever had any of the following?

Y N Abnormal bleeding
Y N blood disorders
Y N Sickle cell disease
Y N Operations
Y N Hospital stay
Y N Cancer
Y N Hepatitis
Y N Epilepsy
Y N Pregnant
Y N Latex allergy
Y N Allergies to drugs
Y N Food allergies
Y N Heart disease or murmur
Y N HIV+/AIDS
Y N Rheumatic/ Scarlet Fever
Y N Asthma
Y N Congenital birth defects
Y N Autism
Y N Kidney or liver condition
Y N Hearing impairment
Y N ADD/ADHD
Y N Disabilities/ Special needs
Y N Diabetes
Y N Tuberculosis

If you marked any of the above as yes, please give details:_____
_____
_____
Please list any other medical conditions:
_____
_____
_____
Please list all of child's allergies:
_____
_____
_____

Medical Provider:

Primary care facility: _____
Physician's name: _____
Phone Number: (____)_____

Please indicate you child's current dental health:

----------O----------O----------O----------O---------
Excellent Good Fair Poor

Acknowledgement & Authority

Since the child is a minor, it is necessary for us to obtain signed permission from a parent or guardian before any dental services can be rendered. The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in my child's medical status. **I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT FOR DENTAL COPAYMENTS AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE.**

Signature of parent or guardian Date Relationship to child