



# Welcome To Growing Smiles Pediatric Dentistry!

## Tell Us About Your Child

Today's Date \_\_\_ / \_\_\_ / \_\_\_ Child's Full Name \_\_\_\_\_  
First Last Preferred Name

Address: \_\_\_\_\_ Child's Home Phone: \_\_\_\_\_  
Street City State Zip

Child's Social Security #: \_\_\_\_\_ Male/Female \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
circle mm/dd/yyyy

## Who Is Accompanying the Child Today?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Do you have legal custody of the child? **Yes / No**  
First Last

## Emergency Contact Information

Name \_\_\_\_\_ Relationship to Child \_\_\_\_\_  
First Last

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_  
Street City State Zip circle

## Parent/Guardian Information

**The Person Responsible For Payment is**  Mother  Father  Other **Marital Status**  Married  Divorced  Single

**Mother's Name** \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_  
First Last circle

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street City State Zip mm/dd/yyyy

**Father's Name** \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_  
First Last circle

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street City State Zip mm/dd/yyyy

**Email Address** \_\_\_\_\_ Would you like to receive email reminders? **Yes / No**

## Primary Insurance Information

**Name of Insured** \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_  
First Middle Last circle

DOB: \_\_\_\_\_ Member ID#: \_\_\_\_\_ Group#: \_\_\_\_\_  
mm/dd/yyyy

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street City State Zip mm/dd/yyyy

**Insured's Employer Name** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Insured's Plan Name** \_\_\_\_\_

Patient's Relationship to Primary Insured:  Self  Spouse  Child  Other

## Secondary Insurance Information

**Name of Insured** \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work/Cell: \_\_\_\_\_  
First Middle Last circle

DOB: \_\_\_\_\_ Member ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_ DOB: \_\_\_\_\_  
Street City State Zip mm/dd/yyyy

**Insured's Employer Name** \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip

**Insured's Plan Name** \_\_\_\_\_

Patient's Relationship to Primary Insured:  Self  Spouse  Child  Other

## Child's Dental History

What is the primary purpose of today's visit? \_\_\_\_\_

- Is the child currently in pain? Yes / No

- Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes / No

- Has the child experienced problems with previous dental work? Yes / No

- Is the child's water fluoridated? Yes / No

- Does the child brush and floss his/her teeth daily? Yes / No

Name of Child's Current Dentist \_\_\_\_\_

Date of Last Visit to Dentist \_\_\_\_\_ Describe Child's Behavior \_\_\_\_\_

Please check all of the following that apply to the child:

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Lip Sucking/Biting | <input type="checkbox"/> Tongue/Cheek Biting   | <input type="checkbox"/> Pacifier           | <input type="checkbox"/> Chewing on Objects |
| <input type="checkbox"/> Tongue Thrust      | <input type="checkbox"/> Thumb/Finger Sucking  | <input type="checkbox"/> Clench/Grind Teeth | <input type="checkbox"/> Nail Biting        |
| <input type="checkbox"/> Speech Problems    | <input type="checkbox"/> Nursing/Bottle Habits | <input type="checkbox"/> Mouth Breather     | <input type="checkbox"/> Breast Fed         |

## Medical History

Child's Physician \_\_\_\_\_ Phone \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Is the child currently under the care of a physician? Yes / No

Describe the child's current physical condition:  Good  Fair  Poor

Are the child's immunizations current? Yes / No

Please list all drugs the child is currently taking: \_\_\_\_\_

Please list all drugs that may cause an allergic reaction: \_\_\_\_\_

Is there anything that you would like to discuss with the doctor in private? Yes / No

Please indicate if the child has or had any of the following:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding   | <input type="checkbox"/> Allergies               | <input type="checkbox"/> AIDS/HIV              | <input type="checkbox"/> Anemia             |
| <input type="checkbox"/> ANY hospitalization | <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Blood Transfusion     | <input type="checkbox"/> Cancer             |
| <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Convulsions           | <input type="checkbox"/> Diabetes           |
| <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Handicaps/Disability    | <input type="checkbox"/> Hearing Impairment    | <input type="checkbox"/> Heart Murmur       |
| <input type="checkbox"/> Tuberculosis        | <input type="checkbox"/> Hemophilia              | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> High Blood Press.  |
| <input type="checkbox"/> Hives               | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Liver Problems        | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Lupus               | <input type="checkbox"/> Measles                 | <input type="checkbox"/> Mitral Valve Problems | <input type="checkbox"/> Mononucleosis      |
| <input type="checkbox"/> Rheumatic Fever     | <input type="checkbox"/> Scarlet Fever           | <input type="checkbox"/> Sickle Cell Anemia    | <input type="checkbox"/> Skin Rash          |

Other: \_\_\_\_\_

Kelli Henderson, DDS

Date Medical/Dental History Reviewed

## Referral Information

Who may we thank for referring you to our practice?  Another Patient \_\_\_\_\_

Dentist/Dental Office \_\_\_\_\_  Yellow Pages  Newspaper  Internet  Other \_\_\_\_\_

## Consent for Services

As a condition of your child's treatment by Growing Smiles, LLC, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients/parents for the costs incurred in their care and financial responsibility on the part of each patient/parent must be determined before treatment. A service charge of 1.5% per month on the unpaid balance will be charged on all accounts exceeding 60 days.

State law requires that a parent or guardian consent to dental services. By signing below, I affirm to the best of my knowledge that the information given above is correct. I understand that providing incorrect or inaccurate information can be dangerous to the child's health. I further understand that the information will be held in the strictest confidence and that it is my responsibility to immediately inform Growing Smiles, LLC of any changes in the child's medical status. I authorize the dental staff at Growing Smiles, LLC to perform any necessary dental services that my child may need. I understand that payment for services will be due on the date they are provided. I further grant permission to Growing Smiles, LLC, to telephone me at my home, cell phone or work to discuss matters related to this form.

Print Name

Signature of Parent

Date