

WELCOME!

*Thank you for choosing Smiles For Life Dentistry! To help us meet all your dental healthcare needs, please fill out the **five boxes** completely.*

1 Patient Information

Name _____ Date _____

Address _____

_____ city _____ state _____ zip _____

Birthdate: _____ Gender: F M Age _____

Patient SS#: _____ - _____ - _____

Parent's or guardian's name: _____

How did you hear of us? _____

2 Phone Numbers

Home Phone _____

Work _____ Cell _____

Spouse's Work _____

What is the best way to reach you? _____
Time of day? _____

Email: _____

I would like to receive e-mail reminders of my appointments
YES NO

EMERGENCY CONTACT
(someone who does not live with you)
Name _____

Relationship _____

Phone #'s _____

3 Dental Insurance

Primary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____
Employer _____ Insurance Co. _____
Insurance Co. Phone # _____ Group # _____
Relation to Patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____
Employer _____ Insurance Co. _____
Insurance Co. Phone # _____ Group # _____
Relation to Patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment.

Signature _____ Date _____

4

Child Dental History

Date of last cleaning? _____ Date of last x-rays? _____
Any known dental problems or concerns at this time? _____

Eating Habits

- Does your child need a bottle or something to drink to go to sleep? Yes No
- Does he or she wake up at night and eat or drink? Yes No
- How many snacks does your child eat each day? (juice alone counts as a snack)? _____
- Does he or she drink any beverage from a cup/sippy cup/bottle throughout the day? Yes No
- Do you give your child something to eat or drink after you finish brushing at night? Yes No

Fluoride

- Do you have city or well water? _____
- Do you have any water filtration systems at home or drink bottle water regularly? Yes No

Brushing

- Does he/she brush teeth daily? Yes No
- Does he/she use floss every day? Yes No
- Does he/she have help brushing their teeth? Yes No

Teeth

- Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle? Yes No
- Has he or she ever fallen and injured the front or back teeth? Yes No

5

Child Medical History

Date of last health exam: _____ What was this exam for? _____

- Is child under care of physician now? Yes No
- Receiving any medication or drug? Yes No
- Ever had surgery? Yes No
- Bleeds easily when cut? Yes No

Medications & reason for taking:

Allergies: _____

Has child had any history of or difficulty with any of the following? If yes, please check

- Asthma Diabetes Fainting Kidney Disease Liver Disease Rheumatic Fever Tuberculosis
- Cancer ADD Epilepsy Heart Condition AIDS or HIV Thyroid Disease Hepatitis
- Gag reflex Other _____

I understand the above information is necessary to provide dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. I will notify the doctor of change in health and medication.

Parent Signature

Date

Doctor Signature

Date