Welcome to Sunny Smiles Dentistry for Children and Young Adults.

We are committed to creating a positive attitude toward dentistry and oral health. Please take a few minutes to fill out the following form. We look forward to working with you to maintain your child's dental health!

REASON FOR VISIT: **DATE**: ____________________

________Examination, X-rays if necessary, cleaning and fluoride treatment

________Pain, discomfort, accident or emergency care

________Consultation regarding

PATIENT HISTORY RECORD

____

FIRST NAME MIDDLE LAST NAME NICKNAME

AGE________ DATE OF BIRTH____________________ MALE_____FEMALE______ HOME PHONE______________

HOME ADDRESS____CITY__________________________ZIP__________

E-MAIL ADDRESS____

Whom may we thank for referring you?__________________________CHILD'S SCHOOL______________________GRADE_______

FIRST NAMES OF THE CHILD'S SIBLINGS: ________________________________

DENTAL HISTORY:

Y N Is this your child's first visit to the dentist? If not, approximate date of child's last visit____________

____

Y N Is your child's water fluoridated?

Y N Is your child taking any fluoride supplements?

Y N Has your child ever had any jaw pain or tenderness?

Y N Does your child brush their teeth daily?

Y N Does your child floss their teeth daily?

Does your child have any of the following habits?

Y N Finger or thumb sucking / pacifier

Y N Grinding / Bruxism

Y N Nail biting

Y N Mouth breathing

Y N Nursing bottle habits / breast-feeding

ARE THERE ANY OTHER CONCERNS YOU WOULD LIKE TO BRING TO OUR ATTENTION?

____

____

MEDICAL HISTORY:

Height ________________Weight ____________________

Child's Physician__________________________________

Family Dentist____________________________________

Phone #_______________Date of last visit_____________

Child's current physical health:

Good _________Fair ____________Poor ______________

Please list all medications your child is currently taking:

____

____

____

MEDICAL HISTORY CONTINUED:

Has your child ever had any of the following medical problems?

Y N Blood Transfusion

Y N Cerebral Palsy

Y N Heart Murmur

Y N Cancer / Tumors

Y N Diabetes

Y N Rheumatic Fever

Y N HIV+/AIDS

Y N Anemia / Blood Disorders

Y N Asthma / Breathing Problems

Y N Hepatitis / Jaundice

Y N Tuberculosis (TB)

Y N Congenital Heart Defect

Y N Seizures / Epilepsy

Y N Abnormal Bleeding

Y N Hearing Impairments

Y N Any Operations

Please explain:____________________________

Y N Any hospital stays

Please explain:____________________________

Y N Kidney / Liver problems

Y N Handicaps / Disabilities / Special Needs

Please explain:____________________________

Y N Allergies to any drugs

Y N Latex Allergy

Y N Food Allergies

Please list all medications your child is allergic to:

____

Please discuss any medical conditions your child has:

____

MOTHER'S INFORMATION
Mother's name________________________________
SS #_______-_____-_____ Birth date________________
Address (if different)______________________________
____
Home phone_________________________________
Work phone_________________________________
Cell phone__________________________________
Occupation_________________________________
Employer___________________________________
Employer's address___________________________

FATHER'S INFORMATION
Father's name________________________________
SS #_____-______-________Birth date_________________
Address (if different)______________________________
____
Home phone_________________________________
Work phone_________________________________
Cell phone__________________________________
Occupation_________________________________
Employer___________________________________
Employer's address___________________________

DENTAL INSURANCE INFORMATION

Name of 1st Insurance_______________________________ Group #____
Subscriber Name________________________ DOB____________________SS#__________-______-_______________
Employer______________________ Phone #_________________ Address_____________________________________
Relationship to child: mother___father___step-mother___step-father___guardian___other___

Name of 2nd Insurance___________________________ Group # _____________________________________
Subscriber Name _____________________ DOB__________________SS# ________-______-_____________
Employer__________________Phone #_______________ Address__________________________________
Relationship to child: mother___father___step-mother___step-father___guardian___other___

Emergency Contact: (list someone who does not live in household)
Name_______________________________________ Phone #____

NAME OF PERSON RESPONSIBLE FOR ACCOUNT ____
Address (if different)_________________________ Home Phone_________________ Work Phone__________________

CONSENT FOR DENTAL TREATMENT:

Before any dental procedures are performed including radiographs, diagnostic aids, local/topical anesthesia, nitrous oxide, oral sedation or general this signed permission statement must be obtained from the parent/guardian. Some risks and complications are known to be associated with dental procedures, although their occurrence is not frequent. The most common complications associated with pediatric dental treatment include: nausea the administration of topical fluoride rinses, biting tongue/lip following the administration of local anesthesia. Less common complications includ numbness, infection, prolonged bleeding, discoloration, vomiting and injury to nerves near treatment site, fracture of tooth root, which may require surgery for removal. Children with HEART disease are required to take antibiotics before and following dental treatment to minimize the risk of s bacterial endocarditis (heart infection). You, the parent/guardian, will be informed of ALL dental services and fees for services BEFORE any are your child.

I hereby certify that the foregoing information is correct and that I have read and understand this consent form.

Signature of Parent or Guardian________________________________**Date**____________________________

History Update: The parent or guardian who accompanies the child at each visit is responsible for payment at the time of service unless prior arrangements have been approved.
I have reviewed my child's health history and it is correct.

DATE____________**SIGNATURE**________________________**COMMENTS**__________________________
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