WELCOME!

Pediatric Dentistry

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a healthy and beautiful smile that lasts a lifetime.

CHILD'S LEGAL NAME: _____ (first) _____ (MI) _____ (last) / _____ (NAME CHILD PREFERS) BIRTHDATE: _____ M or F (circle)

ADDRESS: _____ (street) _____ (city/zip) EMAIL: _____ (appointment reminders)

PLEASE LIST NAME(S) OF OTHER CHILDREN IN YOUR FAMILY WHO HAVE BEEN SEEN IN OUR PRACTICE:

_____

PERSON(S) FINANCIALLY RESPONSIBLE: *The parent or guardian who accompanies the child IS RESPONSIBLE for payment unless prior arrangements have been made.*

_____
name(s) address (if different than child's)

PARENT 1

NAME: _____ RELATIONSHIP TO CHILD: _____

ADDRESS: _____ (only if different than child's) (street) (city/zip) ( ) _____ cell phone

EMPLOYER: _____ (name of business) (union name) (local #) ( ) _____ alternate phone

DENTAL INSURANCE CO.: _____ GROUP # _____

SOC. SEC. #: _____ INSURANCE I.D. #: _____ BIRTHDATE: _____

PARENT 2

NAME: _____ RELATIONSHIP TO CHILD: _____

ADDRESS: _____ (only if different than child's) (street) (city/zip) ( ) _____ cell phone

EMPLOYER: _____ (name of business) (union name) (local #) ( ) _____ alternate phone

DENTAL INSURANCE CO.: _____ GROUP # _____

SOC. SEC. #: _____ INSURANCE I.D. #: _____ BIRTHDATE: _____

OTHER INSURED

NAME OF INSURED: _____ EMPLOYER: _____

ADDRESS: _____ DENTAL INSURANCE CO.: _____

SOCIAL SECURITY #: _____ BIRTHDATE: _____ INSURANCE I.D.# _____

RELATIONSHIP TO CHILD: _____ GROUP #: _____

SIGNATURE FOR CELL PHONE AND BILLING:* I consent to the use of my cell phone number to call and/or text re: appointments, treatment, insurance and my account. I understand that I can withdraw my consent at any time. **I also authorize the use of my signature on file if needed for insurance billing purposes and further authorize payment of insurance benefits, otherwise payable to me directly to Drs. Schmitt & Saini. Where appropriate, a credit report may be obtained.

_____
signature

PLEASE COMPLETE REVERSE SIDE

HOW DID YOU FIND US? _____
Name if applicable

CHILD'S SPECIAL INTEREST(S) (pets / hobbies / etc.): _____

(circle one)

Y / N **1. IS YOUR CHILD CURRENTLY UNDER MEDICAL TREATMENT?** _____ describe

Y / N **2. IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION?** _____ list

3. WHO IS YOUR CHILD'S PHYSICIAN? _____ name _____ phone #

Y / N **4. IMMUNIZATIONS UP TO DATE?** **DATE OF LAST EXAM:** _____

5. DOES YOUR CHILD HAVE A HISTORY OF ANY OF THE FOLLOWING:

Y / N ALLERGIES ☐ TO FOOD ☐ TO POLLEN ☐ TO DUST ☐ TO LATEX _____ list others

Y / N REACTIONS TO MEDICINES/NOVOCAINE, CODEINE, PENICILLIN, ETC. _____ list

Y / N HEART TROUBLE _____ describe

Y / N HEAD OR BRAIN INJURIES _____ describe

Y / N PHYSICAL AND/OR MENTAL LIMITATIONS _____ describe

Y / N	LIVER DISEASE	Y / N	IMMUNE DEFICIENCY	Y / N	MOTION SICKNESS
Y / N	DIABETES	Y / N	PROLONGED BLEEDING	Y / N	SPEECH DISORDER
Y / N	EPILEPSY	Y / N	ASTHMA	Y / N	PHOBIAS _____
Y / N	HEPATITIS	Y / N	ANEMIA	Y / N	EMOTIONAL PROBLEMS
Y / N	TUBERCULOSIS	Y / N	DELAYED DEVELOPMENT	Y / N	SCHOOL PROBLEMS
Y / N	RHEUMATIC FEVER	Y / N	HEARING DIFFICULTIES	Y / N	ATTENTION DIFFICULTIES
Y / N	RESPIRATORY AILMENTS	Y / N	GAG REFLEX	Y / N	EPISODES OF HIGH FEVER
Y / N	KIDNEY DISEASE	Y / N	AUTISM		

Y / N **6. IS THIS YOUR CHILD'S FIRST VISIT TO A DENTAL OFFICE?**

7. IF NOT, LAST DENTAL VISIT WAS _____ date **WITH** _____ name _____ phone #

Y / N **8. HAVE THERE BEEN ANY UNFAVORABLE DENTAL EXPERIENCES?** _____ describe

_____

9. DOES YOUR CHILD HAVE ANY OF THE FOLLOWING HABITS? (If not presently, at what age did the habit stop?)

Y / N	THUMB/FINGER SUCKING	Y / N	NAIL BITING	Y / N	GRINDING
Y / N	PACIFIER	Y / N	TAKING BREAST/BOTTLE TO BED		

10. WHAT IS YOUR CHILD'S PRIMARY SOURCE OF WATER? _____ name of water company

Y / N **11. IS YOUR CHILD'S WATER FLUORIDATED?**

Y / N **12. IS YOUR CHILD TAKING FLUORIDE SUPPLEMENTS?**

Y / N **13. HAVE THERE BEEN ANY INJURIES TO TEETH?** _____ describe

14. FAMILY DENTAL HISTORY:

Y / N DOES AN ADULT ASSIST WITH BRUSHING?

Y / N DOES AN ADULT ASSIST WITH FLOSSING?

Y / N HAS EITHER PARENT BEEN TREATED ORTHODONTICALLY?

MOTHER'S CHILDHOOD DECAY EXPERIENCE: ☐ LOW ☐ AVERAGE ☐ HIGH

FATHER'S CHILDHOOD DECAY EXPERIENCE: ☐ LOW ☐ AVERAGE ☐ HIGH

15. ANY ADDITIONAL INFORMATION ABOUT YOUR CHILD WE SHOULD KNOW? _____

_____

I, BEING THE PARENT, GUARDIAN, CUSTODIAN OF THE ABOVE MINOR, DO HEREBY AUTHORIZE SUCH DENTAL CARE, INCLUDING THE USE OF LOCAL ANESTHETICS AND NITROUS OXIDE/OXYGEN ANALGESIA, AND OTHER MEDICATIONS AS THE JUDGMENT OF THE DENTIST MAY DICTATE.

_____ Signature _____ Date _____ Reviewed by

★ FOR OFFICE USE ONLY ★ FOR OFFICE USE ONLY ★ FOR OFFICE USE ONLY ★ FOR OFFICE USE ONLY ★ FOR OFFICE USE ONLY ★