Where Happy, Healthy Smiles are Second Nature.
Thanks for selecting us! www.mysmileinbloom.com

Smiles in Bloom
PEDIATRIC DENTISTRY

Date: _____

Child's Name: _____
Last First Middle

Nickname: _____ Gender: ☐ Male ☐ Female

Date of Birth: _____ Age: _____ Phone: _____

Your Child

School:_____ Grade: _____
Home Address:_____City:_____State:_____Zip_____
Who is accompanying child today?_____
Whom may we thank for referring you? _____
Name and ages of other children in family: _____

Parent or Guardian Information ☐ Mother ☐ Father ☐ Stepmother ☐ Guardian ☐ Other

Name:_____ Relationship to Patient: _____
Address:_____
Cell Phone:_____ Home:_____ E-mail:_____
Employer: _____ Occupation: _____ SS#: _____ DL#: _____
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Parent or Guardian Information ☐ Mother ☐ Father ☐ Stepfather ☐ Guardian ☐ Other

Name:_____ Relationship to Patient: _____
Address:_____
Home Phone:_____ Cell :_____ Work:_____
Employer: _____ Occupation: _____ SS#: _____ DL#: _____
Marital Status: ☐ Married ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

Emergency Contact Information

Name:_____ Relationship to Patient: _____
Address:_____
Home Phone:_____ Cell :_____ Work:_____

Insurance Information

Primary Insurance
Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Secondary Insurance
Name of Insured_____DOB_____Relationship to Patient _____
SSN#:_____ Name of Employer:_____ Work Phone: (____)_____
Address of Employer:_____City_____State:_____Zip _____
Insurance Company_____ Grp #_____ ID#_____
Ins Co Address:_____ Ins Co. Phone:_____

Health History: Medical

Has your child ever hand any of the following:

Y	N		Y	N		Y	N		Y	N		Y	N		Y	N	
☐	☐	Aids	☐	☐	Brain Injury	☐	☐	Communicable Disease	☐	☐	Endocrine/Growth Disorders	☐	☐	Hepatitis	☐	☐	Pneumonia	☐	☐	Sickle Cell Anemia
☐	☐	ADHD	☐	☐	Bronchitis	☐	☐	Convulsions/Seizures	☐	☐	Eye Problems	☐	☐	Jaundice	☐	☐	Pregnancy	☐	☐	Sinus Problem/Snoring
☐	☐	Anemia	☐	☐	Cancer	☐	☐	Developmental Delay	☐	☐	Fainting / Dizziness	☐	☐	Leukemia	☐	☐	Psychiatric Disorder	☐	☐	Sore throat
☐	☐	Allergy/Asthma	☐	☐	Cerebral Palsy	☐	☐	Diabetes	☐	☐	Hearing Loss	☐	☐	Measles	☐	☐	Rheumatic Fever	☐	☐	Enlarged Tonsils
☐	☐	Autism	☐	☐	Chicken Pox	☐	☐	Drug or Alcohol Abuse	☐	☐	Heart Disease/Murmur	☐	☐	Mental Retardation	☐	☐	Scarlet Fever	☐	☐	Spina Bifida
☐	☐	Bleeding Abnormalities	☐	☐	Cleft Lip/Palette	☐	☐	Epilepsy	☐	☐	Hemophilia	☐	☐	Mumps	☐	☐	Scoliosis	☐	☐	Tuberculosis
☐	☐	Other (please identify)																		

☐ This child has never been diagnosed as having any of the above conditions.

Please explain any checked items:

_____

Child's Physician: _____ Phone: _____

Address: _____

Date of last exam (list results): _____

Please list any serious medical problem, hospitalization or surgeries the child has had: _____

_____

Please list all medications the child is currently taking (give reasons): _____

Premedication prior to dental treatment? ☐ Yes ☐ No Why? _____

Is your child in the care of a specialist for any reason? ☐ Yes ☐ No Why? _____

Specialist's name: _____ Phone: _____

Does your child have a physical or medical disability/delay? ☐ Yes ☐ No Please list: _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc)?

☐ Yes ☐ No (If yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Is the child up to date on immunizations? ☐ Yes ☐ No

Do you wish to speak to the doctor privately about a special concern? ☐ Yes ☐ No

Health History: Dental

How often does your child brush: _____ Floss? _____ Is brushing/flossing supervised? ☐ Yes ☐ No By whom? _____

Is your child's water fluoridated? ☐ Yes ☐ No ☐ Don't know Is your child receiving fluoride supplements? ☐ Yes ☐ No

☐ Tablets ☐ Drops Dose: _____

Is this your child's first dental visit? ☐ Yes ☐ No Previous Dentist & City: _____ Date of last visit: _____

Date of last dental x-ray: _____ Any injuries to your child's teeth or jaw? ☐ Yes ☐ No When/What? _____

Has your child had recent dental pain? ☐ Yes ☐ No Explain: _____

☐ Breast feeding (till age) _____ ☐ Bottle (till age) _____ ☐ Thumb/Finger Sucking _____

☐ Pacifier (till age) _____ ☐ Nail Biting ☐ Dental Grinding/Clenching ☐ Mouthbreathing/Snoring

Has your child experienced any unfavorable reaction from previous medical or dental care? ☐ Yes ☐ No

Explain: _____

Smiles in Bloom PEDIATRIC DENTISTRY

Photo Release Consent

I hereby give my consent for Dr. Justin Bloom and Smiles in Bloom Pediatric Dentistry to use my child's photograph for internal marketing and advertising. I attest that I am the parent or guardian of the child. I have read this release and approve of its terms. I hereby freely and voluntarily consent to the use of my child's photograph as stated above until I revoke this consent in writing.

Signature of parent/guardian:_____ Date: _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of parent/guardian:_____ Date: _____