

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



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

- | | | | |
|--|--|--|---|
| Y N | <input type="checkbox"/> Aids | Y N | <input type="checkbox"/> Brain Injury |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Communicable Disease | <input type="checkbox"/> Endocrine/Growth Disorders |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer | <input type="checkbox"/> Convulsions/Seizures | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Allergy/Asthma | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Fainting / Dizziness |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Bleeding Abnormalities | <input type="checkbox"/> Cleft Lip/Palette | <input type="checkbox"/> Drug or Alcohol Abuse | <input type="checkbox"/> Heart Disease/Murmur |
| <input type="checkbox"/> Other (please identify) | | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hemophilia |

Has your child ever had any of the following:

- | | | | | | |
|-----------------------------------|---|--|--|--|---|
| Y N | <input type="checkbox"/> Hepatitis | Y N | <input type="checkbox"/> Pneumonia | Y N | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Jaundice | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Intellectual Disability | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sinus Problem/Snoring | |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Psychiatric Disorder | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Sore throat | |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rheumatic Fever | | <input type="checkbox"/> Scarlat Fever | <input type="checkbox"/> Enlarged Tonsils | |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Scoliosis | | | <input type="checkbox"/> Spina Bifida | |
| | | | | <input type="checkbox"/> Tuberculosis | |

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: _____

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: _____