Smiles in Bloom Pediatric Dentistry
137 Prospect Hill Rd. East Windsor, CT 06088
P: 860-254-5840
F: 860-254-5830

Date: _____

Child's Name:_____ Birth sex: ___Male ____Female
Last First Middle

Preferred name/pronouns:_____ Gender identity: ___Male ____Female

Date of birth: _____ Age: _____ Phone #: _____

Your child:
School: _____ Grade:_____
Home Address: _____ City:_____State:_____ Zip:_____
How did you hear about our office?_____
Name(s) and age(s) of other children in family:_____

Parent or guardian information:
Name: _____ Relationship to patient:_____
Address:_____
Cell phone: _____ Home phone:_____ Email:_____
Employer: _____ Occupation:_____ SSN: _____ DL#:_____
Marital status: ▢Married ▢ Single ▢Separated ▢Divorced ▢Widowed

Parent or guardian information:
Name: _____ Relationship to patient:_____
Address:_____
Cell phone: _____ Home phone:_____ Email:_____
Employer: _____ Occupation:_____ SSN: _____ DL#:_____
Marital status: ▢Married ▢ Single ▢Separated ▢Divorced ▢Widowed

Emergency contact information:

Name: _____ Relationship to patient:_____
Address:_____
Cell phone: _____ Home phone:_____ Work phone:_____

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: _____

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Authorization for person other than parent or guardian to consent to treatment of minor child

I_____do hereby authorize _____ to consent to any dental treatment in my absence with the advice of a licensed dental professional.

Name: _____ Relationship to patient: _____

Contact information: _____

Health history: Medical **Has your child ever had any of the following:**

Yes	No	Condition	Yes	No	Condition	Yes	No	Condition	Yes	No	Condition
		AIDS			Chicken pox			Hemophilia			Pregnancy
		ADHD			Cleft lip/palate			Eye problems			Psychiatric disorder
		Anemia			Cystic fibrosis			Fainting/dizziness			Rheumatic fever
		Allergy/Asthma			Autism			Hearing loss			Scarlet fever
		Communicable disease			Endocrine/growth problems			Heart disease/murmur			Intellectual disability
		Bleeding abnormality			Developmental disorder			Eczema/ skin problems			Hydrocephalus/shunt
		Birth defects			Diabetes			Sickle cell anemia			Sinus problems/snoring
		Brain injury			Drug/alcohol abuse			Hepatitis			Thyroid problems
		Cancer			Seizures			Liver problems			Enlarged tonsils
		Cerebral palsy			Digestive issues			Scoliosis			Spina bifida

___ 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 any findings):_____

Please list all medications your child is currently taking:_____

Premedication prior to dental treatment: ▢Yes ▢No Why?_____

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

Specialist's name:_____ Phone #:_____

Allergies/ sensitivities/ adverse reactions to any drugs/medications or other substances? __Yes __No

Please describe: _____

Is your child up to date on immunizations? ▢Yes ▢No

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Health history: Dental

How often does your child brush:_____ Floss:_____ Is oral hygiene supervised ▢Yes ▢No
Is your child's water fluoridated? ▢Yes ▢No ▢Not sure. Is your child receiving fluoride supplements? ▢Yes ▢No
Is this your child's first dental visit? ▢Yes ▢No Previous Dentist & City: _____ Date of Last visit: _____
Any injuries to your child's teeth or jaw? ▢Yes▢No Please describe: _____
Any dental pain? ▢Yes ▢No Explain:_____
▢Breast feeding (until age)_____ ▢Bottle (until age)____ ▢Nail biting ▢Grinding/Clenching
▢Pacifier (until age)____ ▢Thumb/finger sucking _____ ▢Mouth breathing/snoring
Any unfavorable reaction to medical or dental care in the past? __Yes __No
Explain:_____

Photo release consent

I hereby give my consent for 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:_____