WELCOME TO LITTLE SMILES

Help us to get to know your family

How did you hear about us? _____

YOUR CHILD:

Child's name _____ Nickname_____ Male☐ Female☐
Birth date _____ Age_____ Social security #_____
Child's home address_____
City_____ Zip _____
Best email to receive appointment reminders _____
Best contact phone # (_____) _____
Child's doctor_____ Phone # (_____) _____
Previous Dentist_____ Date of last visit_____
How was previous dental appointment? _____

PARENT 1:

Full name_____
Married☐ Single☐ Divorced☐ Separated☐ Widowed☐
Birth date_____
If Different from Above:
Address_____
City_____ Zip _____
H # (_____) _____ C # (_____) _____ W # (_____) _____
Email address_____
Employer_____ Job title_____

PARENT 2:

Full name_____
Birth date_____
If address is different from above:
Address_____
City_____ Zip _____
H # (_____) _____ C # (_____) _____ W # (_____) _____
Email address_____
Employer_____ Job title_____

INSURANCE INFORMATION:

Insurance Co. name_____
Insurance Co. Phone# (_____) _____
I.D. # _____ Group #_____
Policy owner's name_____
Policy owner's birth date _____
Relationship to patient_____
Policy owner's employer_____
Employer's address_____
SECONDARY INSURANCE yes☐ no☐

PLEASE SEE BACK PAGE

Why did you bring your child to the dentist today?_____
What concerns do you have? _____
Please give us an idea of what you expect today_____
_____
Is your child having a pleasant experience the most important aspect of this appointment? Yes☐ No☐
Is your child receiving a very thorough exam the most important aspect of this appointment? Yes☐ No☐
Please give us an idea of the best way to approach your child or any other aspects of your child you feel are important._____
_____
_____
_____
How often does your child drink juice/soda? _____
Is your child using a bottle or breast feeding at night? Yes ☐ no ☐
Does your child have a finger/thumb/binky habit? yes☐ no☐ Does this concern you? yes☐ no☐
Has your child ever been sedated for dental treatment? yes☐ no☐
Does your child see an orthodontist?_____ If so, who_____ Last visit_____
Please list any medications your child is taking and why_____
Is your child up to date with immunizations? yes☐ no☐
Does your child have allergies to medications or foods? If so what_____

Has your child ever had any of the following?

Y☐ N☐	abnormal bleeding	Y☐ N☐	autism spectrum
Y☐ N☐	diabetes	Y☐ N☐	cancer
Y☐ N☐	digestive tract/reflux problems	Y☐ N☐	hearing/ vision/speech impairment
Y☐ N☐	asthma/respiratory difficulty	Y☐ N☐	kidney/ liver problems
Y☐ N☐	ADHD/ADD or learning difficulty	Y☐ N☐	sleep apnea

Has your child had any surgeries/hospitalizations/serious illness? yes☐ no☐
Please comment on any of these or other medical concerns_____
_____

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 dental services my child may need.

_____ _____
Signature of parent Date

_____ _____
Signature of Dentist Date

Clear Form Print Form Email Form