The Smile Shop
Patient Information

Who may we thank for referring you?:______________________________ Date: __________

Child's Name: ____
First MI Last

Nickname: ________________________________ Birth Date: __________ Age: ____ ☐ Male ☐ Female

Your child's interests/sports ____

School:______________________ Grade: ______________

Has our office previously seen any siblings? ☐ Yes ☐ No Pets:______________

Name/Age of siblings: Brothers: ______________________ Sisters: ______________________

Family Information

Mother's Name:____________________________________ Birth Date: __________

Relationship of the Mother to child: ☐ Biological parent ☐ Adoptive parent ☐ Step-parent ☐ Guardian (relation)__________

Mailing address: ____
Street / P.O. Box City State Zip Code

Home phone (___)__________ Work phone (___)__________ Cell phone (___)__________

Employer: ______________________ Occupation: ______________________

Social Security Number: ______________________

Email Address:______________________

Father's Name: ____________________________________ Birth Date: __________

Relationship of the Father to child: ☐ Biological parent ☐ Adoptive parent ☐ Step-parent ☐ Guardian (relation)__________

Mailing address: ____
Street / P.O. Box City State Zip Code

Home phone (___)__________ Work phone (___)__________ Cell phone (___)__________

Employer: ______________________ Occupation: ______________________

Social Security Number: ______________________

Email Address:______________________

Legal Custody is with (please circle):	Mom	Dad	Both	Biological Parent(s)	Guardian(s)
Child lives with (please circle):	Mom	Dad	Both	Biological Parent(s)	Guardian(s)

PLEASE NOTE: If Legal Guardians are NOT the Biological parents, we must have current copies of court papers for our records.

Emergency Contact (Specify someone who **does not live** in your household.)

Family (or close friend) Name: ______________________ Phone:______________

Cell Phone: ______________ Relationship to Patient:______________

Address: ____

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 status.

To ensure the safety of the patient, staff and dentist, it may be necessary to limit the patient's freedom of movement. In our office, this is most commonly accomplished by holding the patient's hands. Hand holding is either performed by the parent or a staff member to allow the safe completion of treatment or examination. A consultation and written consent with the legal guardian is obtained prior to any form of stabilization.

I hereby authorize Nicole Stoker DDS/Melissa McCool DDS and/or her associates to perform any and all treatment for the above named child and consent to such methods, drugs and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until canceled.

______________________________ ______________________ __________
Signature of Patient, Parent or Guardian Relationship to child Date:

The Smile Shop
Pediatric Medical / Dental History

Patient Name: ______________________ ☐ Male ☐ Female Birth Date: ______________

Although dental personnel primarily treat the area in and around your mouth, the mouth is a part of your entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry your child will receive.

Medical History

Does your child have a primary care physician? ☐ Yes ☐ No If yes, who? ______________

Is your child presently under the care of a specialist for any medical problem? If yes, who? ______________

Cardiologist	☐ Yes ☐ No	Hematologist	☐ Yes ☐ No	Immunologist	☐ Yes ☐ No
Psychologist	☐ Yes ☐ No	Oncologist	☐ Yes ☐ No	Other	☐ Yes ☐ No

Brief Description

Has your child ever been hospitalized or had surgery? ☐ Yes ☐ No If yes ______________

Has your child had any broken bones requiring placement of pins, plates or screws? ☐ Yes ☐ No If yes ______________

Has your child ever had a serious head or neck injury? ☐ Yes ☐ No If yes ______________

Is your child taking any medications, pills, or drugs? ☐ Yes ☐ No If yes ______________

Is your child allergic to any of the following?

☐ Asprin ☐ Penicillin ☐ Codeine ☐ Metal
☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Gluten ☐ Other ______________

Does your child have now, or has he/she had, any of the following?

AIDS/HIV Positive	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Asthma	☐ Yes ☐ No
Blood Disorder	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Seizures/Convulsions	☐ Yes ☐ No	Heart Trouble or Murmurs	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No	Bleeding Disorder	☐ Yes ☐ No	Brain Injury	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Cerebral Palsy	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No	Developmental Delay	☐ Yes ☐ No	Allergies	☐ Yes ☐ No
Drug Sensitivites	☐ Yes ☐ No	Immune Deficiencies	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Kidney/Liver Involvement	☐ Yes ☐ No

Brief Description

Has your child ever had any serious illness not listed? ☐ Yes ☐ No If yes ______________

Medical History Review

____

____

____

Doctor's Signature

Dental History

Has your child been to the dentist before? If yes, please list who your child has seen and the date. ☐ Yes ☐ No If yes ______________

Are there any injuries to your child's teeth or jaws? (Falls, blows, chips etc.) ☐ Yes ☐ No If yes ______________

Does you child have a history of the following?

Thumbsucking	☐ Yes ☐ No	Lip Sucking	☐ Yes ☐ No	Pacifier	☐ Yes ☐ No	Finger Sucking	☐ Yes ☐ No
Nail Biting	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No	Bleeding Gums	☐ Yes ☐ No	Grinding teeth	☐ Yes ☐ No
Clicking/Popping jaws	☐ Yes ☐ No						

Age when habit discontinued ______________

How often does your child brush? ______________

Is toothbrushing supervised? ☐ Yes ☐ No If yes, by whom? ______________

Is dental floss used? ☐ Yes ☐ No

Does you child receive the following?

Fluoride in vitamins	☐ Yes ☐ No	Fluoride in tablets/drop	☐ Yes ☐ No	Fluoridated water	☐ Yes ☐ No	None	☐ Yes ☐ No

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______________ ______________ ______________

Signature of Patient, Parent or Guardian | Relationship to child | Date:

The Smile Shop
Patient Insurance Information

Patient Name: ______________________ Birth Date: __________ Age: ____ ☐ Male ☐ Female

Primary

Name of Policy Holder: ______________________ Relationship to Patient: __________
First Last MI

Policy Holder's Date of Birth: __________ ID/SSN#: __________ Group#: __________

Policy Holder's Employer Name: ______________________

Employer Address: ______________________
Street City State Zip Code

Dental Insurance Company: __________ Insurance Phone #: __________

Dental Insurance Claims Mailing Address ______________________
Street City State Zip Code

Is your child covered under more than one plan? ☐ Yes ☐ No

*** The coordination of primary and secondary insurance is determined by a strict set of guidelines. While we are happy to file your secondary insurance claims for you, we ask that you provide accurate information on your coverage. ***Any errors*** or omissions may lead to the incorrect filing of your claims, which may delay payment. ***

Secondary (Primary and Secondary Insurances are determined by the parent's month of birth)

Name of Policy Holder: ______________________ Relationship to Patient: __________
First Last MI

Policy Holder's Date of Birth: __________ ID/SSN#: __________ Group#: __________

Policy Holder's Employer Name: ______________________

Employer Address: ______________________
Street City State Zip Code

Dental Insurance Company: __________ Insurance Phone #: __________

Dental Insurance Claims Mailing Address ______________________
Street City State Zip Code

I hereby authorize payment of the group dental benefits directly to the dentist. I understand that I am financially responsible for any charges not covered by my insurance.

Signature: __________ Relationship to Patient: __________ Date: __________

As a courtesy to our patients who have dental insurance, we are happy to submit the necessary forms. Because insurance policies can vary greatly, we can only estimate your coverage in good faith, but cannot guarantee coverage, due to the complexities of insurance contracts. We recommend you contact your insurance company directly to verify your coverage for services. **Your estimated patient portion must be paid at the time of service.**

It is important to remember that the policy is a contract between you and your insurance company. We will fully attempt to help you receive full insurance benefits; however, you are responsible for your account. If your insurance policy does not pay within 60 days, **you are responsible for the entire balance, paid in full.** Please keep us informed of any insurance changes, such as policy name, insurance company address, or a change in employment.

I have read the above, and I understand and agree to this financial policy.

Signature of Patient __________

Signature of Responsible Party: __________ Relationship to Patient: __________ Date: __________