southeast smiles
PEDIATRIC DENTISTRY
Something for Kids to Smile About

Registration & Health History Form

Today's Date: _____

Welcome to Southeast Smiles! We provide individualized care for infants, toddlers, children and teens! Our focus is on prevention and early management of dental disease. We are honored that you have entrusted your child's care to us. We take great pride in providing a comfortable experience for children and their families. Should you have any special requests, please inform us and we will do our best to accommodate you.

How did you hear about us? ☐ Event ☐ Facebook ☐ Newspaper ☐ Friend ☐ Internet
Other: _____

Tell us about your child:

Name: _____
Goes by: _____ ☐ Male ☐ Female
Siblings we treat: _____
Birth Date: ____/____/_____ Age:_____
School: _____ Grade: _____
Home address: _____
Home phone: (____) _____
Favorite Movie: _____
Favorite Song/Singer: _____
Favorite Activity/Sport: _____

Who is accompanying your child today?

Name & Relationship:_____
Do you have legal custody of your child? Yes / No

Is there anyone you would like to designate to to bring your child for dental appointments?
Name & Relationship:_____
Name & Relationship:_____

EMERGENCY CONTACT:_____
PHONE #:_____

PARENT ONE:
Do you have legal custody of your child? Yes / No
Name: _____
Relationship: _____ DOB: ___/___/_____
Spouse Name_____
Best contact #: _____ H ☐ C ☐ W ☐
Email: _____
Address:_____

PARENT TWO:
Do you have legal custody of your child? Yes / No
Name: _____
Relationship: _____DOB: ___/___/_____
Spouse Name_____
Best contact #: _____H ☐ C ☐ W ☐
Email: _____
Address:_____

Dental Insurance: (primary)
Insurance Company name
_____
Employer Name
_____
Phone # on card:_____
Group #: _____ Member #: _____
Policy owner's name: _____
Relationship to patient: _____
Policy owner's birth date: ____/_____/_____
S.S.#_____

Dental Insurance: (secondary)
Insurance Company name
_____
Employer Name
_____
Phone # on card:_____
Group #: _____ Member #: _____
Policy owner's name: _____
Relationship to patient: _____
Policy owner's birth date: ____/_____/_____
S.S.#_____

Is there anything we can do to help make your child more comfortable? _____
_____

Dental History:

Is this your child's first dental visit? YES NO
If no, how long since the last visit? _____
Previous dentist's name: _____
Any X-rays taken at previous dental visits? YES NO
Any injuries to the teeth, face or mouth? YES NO
If yes, please explain: _____
_____
Family history of dental problems: YES NO
If yes, please explain: _____
_____
Why did you bring your child to the dentist today? _____
_____
Do you have any dental concerns or questions? _____
_____
Have previous dental visits been positive or negative?
Please explain: _____
_____ _

Do any of the following apply to your child?

Y N Frequent snacking **Y N** Breast Feeding
Y N Sleeping with a bottle **Y N** Pacifier Use
Y N Tooth Grinding **Y N** Sippy Cup Use
Y N Thumb Sucking **Y N** Nail biting

Cups per day of: ____ Milk ____ Juice _____Soda
Types of snacks: _____

Dental care: at home

Brush his/her own teeth? YES NO
If yes, how often? _____ Times a day
Do you brush your child's teeth? YES NO
If yes, how often? _____ Times a day
Does your child floss daily? YES NO
Difficulty brushing his/her teeth? YES NO

Do you floss your child's teeth? YES NO
Does your child use fluoride toothpaste? YES NO
Is your child taking fluoride supplements? YES NO

Medical History:

Has your child ever had any of the following?

Y N Abnormal Bleeding **Y N** Asthma
Y N Heart Murmur/Disease **Y N** Diabetes
Y N Congenital birth defect **Y N** Autism
Y N Kidney/Liver conditions **Y N** Cancer
Y N Rheumatic/Scarlet Fever **Y N** Hepatitis
Y N Hearing impairment **Y N** Epilepsy
Y N Blood Disorders **Y N** HIV+/AIDS
Y N Sickle Cell Disease **Y N** Hospitalizations
Y N Allergic to Drugs **Y N** Latex Allergy
Y N Food Allergies **Y N** Tuberculosis
Y N Pregnancy **Y N** ADHD/ADD

If you marked any of the above as YES, please explain:
_____
_____
_____

Please list any other medical conditions or **allergies**:
_____
_____

Please list all medication your child is currently taking:
_____
_____

MEDICAL PROVIDER/PEDIATRICIAN:

Physician's name: _____
Phone number: **(____)**_____
Primary Care Facility: _____

Please indicate your child's current dental health:

Excellent ☐ Good ☐ Fair ☐ Poor ☐

Acknowledgement & Authority

Since the child is a minor, it is necessary for us to obtain signed permission from a parent or guardian before any dental services can be rendered. The information I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence. I understand that it is my responsibility to inform this office of any changes in my child's medical status. **I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR PAYMENT FOR SERVICES AND AGREE TO PAY FOR THEM AT TIME OF SERVICE.**

_____

Signature of parent or guardian Date Relationship to child