LTHY GURAS HY WELCOME We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with your child. PATIENT INFORMATION Child's Name ____ Soc. Sec. # Last Name Initial First Name _____ State_____ Zip _____ Home Phone _____ City_ Cell Phone _____ Email _____ Sex \(\subseteq M \(\supseteq F \) Age \(\subseteq School \) Hobbies/Sports _____ Whom may we thank for referring you?_____ Notify in case of emergency_____ Home Phone _____Email _____ **Business Phone**

PRIMARY INSURANCE Person Responsible for Account Last Name First Name Initial ______ Birthdate ______ Soc. Sec. # ____ Relation to Child _____ Address (if different from child)_____ City______ State____ Zip _____ Home Phone _____ Cell Phone _____ _____ Email _____ _____ Occupation____ Person Responsible Employed by_____ Business Address Business Phone Business Email _____ Insurance Email ____ Insurance Company____ Phone Contract #______ Group #_____ Subscriber # _____ Name of other dependents under this plan____ Additional Insurance Subscriber Name ______ Relation to Child______ Birthdate ____ Address (if different from child)_____ ____ Soc. Sec. # ____ State_____ Zip ____ Home Phone City Cell Phone ______ Email _____ Business Phone_____ Subscriber Employed by _____ Insurance Email Business Email _____ Insurance Company_____ Phone Group #_____Subscriber # Name of other dependents under this plan____

Please complete both sides.

ST HEALTHY GURAS HYGIE **DENTAL HISTORY** What would you like us to do for your child today?___ Address _____ Former Dentist Phone _____ Dentist's Email Date of last dental care______ Date of last x-rays_____ How often does your child brush? _____ _ Floss? _____ Does your child experience pain or discomfort in the jaw joint? \square Y \square N Has your child ever experienced a mouth or chin injury? □ Y □ N Does your child have speech problems? Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? 🔲 Y 🔲 N Child's habits affecting the mouth or teeth: ☐ Thumb sucking ☐ Nail biting ☐ Other ____ Other information about your child's dental health or previous treatment ____ MEDICAL HISTORY Child's Physician ____ Phone_ Physician's Email _____ Date of last visit ______ Has your child had any serious illnesses or operations? \(\subseteq Y \) \(\subseteq N \) If yes, describe ____ Is your child currently under physician care? □ Y □ N If yes, describe_ If yes, give approximate dates_____ Has your child ever had a blood transfusion? □ Y □ N Has your child ever taken Fen-Phen/Redux? □Y□N Check (✓) yes or no whether your child has had any of the following: ☐ Y ☐ N Shortness of breath ☐ Y ☐ N Cough up blood ☐ Y ☐ N Hemophilia/ ☐ Y ☐ N AIDS/HIV Positive Abnormal bleeding □ Y □ N Sinus problems ☐ Y ☐ N Diabetes □ Y □ N Anemia □ Y □ N Immunizations current ☐ Y ☐ N Skin rash □ Y □ N Asthma ☐ Y ☐ N Epilepsy ☐ Y ☐ N Kidney disease or ☐ Y ☐ N Spina Bifida □ Y □ N Atopic (allergy prone) □ Y □ N Fainting malfunction ☐ Y ☐ N Thyroid disease or □ Y □ N Blood disease □ Y □ N Food allergies ☐ Y ☐ N Liver disease malfunction □ Y □ N Headaches □ Y □ N Cancer □ Y □ N Material allergies □ Y □ N Tonsillitis (latex, wool, metal, ☐ Y ☐ N Chicken Pox ☐ Y ☐ N Hearing Impairment □ Y □ N Tuberculosis chemicals) □ Y □ N Convulsions/Epilepsy ☐ Y ☐ N Heart problems Other □ Y □ N Respiratory disease DYDN □ Y □ N Cough, persistent Describe □ Y □ N Rheumatic/Scarlet fever List medications your child is taking, if any: List drug allergies, if any: **AUTHORIZATION** I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. Signature . Payment is due in full at time of treatment, unless prior arrangements have been approved. #80-783R1 © SmartPractice