Larry Adatto
THE EXCEPTIONAL SMILE EXPERIENCE

1 CHILD'S INFORMATION

Date _____
Child's Name _____
Birthdate _____ Age _____ ☐ Male ☐ Female
Nickname _____ SS # _____
School _____ Grade _____
Hm # _____ Cell # _____
Home Address _____
_____
Email Address _____

2 WHO IS ACCOMPANYING THE CHILD TODAY?

Name _____ Relation _____
Do you have legal custody of this child? ☐ Yes ☐ No
Is child adopted? ☐ Yes ☐ No In a foster home? ☐ Yes ☐ No
Whom may we thank for referring you? _____
Other siblings seen by us _____
Previous / Present Dentist? _____
Last Visit Date _____
Parent's Marital Status ☐ Single ☐ Married ☐ Divorced
☐ Partnered ☐ Widowed ☐ Separated

3 PARENT'S INFORMATION

☐ Mother ☐ Step Mother ☐ Guardian
Name _____ Birthdate _____
Wk # _____ Ext. _____ Cell# _____
Employer _____
SS# _____ DL # _____

☐ Father ☐ Step Father ☐ Guardian
Name _____ Birthdate _____
Wk # _____ Ext. _____ Cell # _____
Employer _____
SS# _____ DL # _____

In the event of an emergency, whom may we contact?
Name _____ Cell # _____
Address _____
_____

4 PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relation _____
Billing Address _____
_____
Wk # _____ Ext. _____ Cell # _____
Employer _____
SS# _____ DL # _____
Who is responsible for making appointments?
Name _____
Wk # _____ Ext. _____ Hm # _____

5 PRIMARY DENTAL INSURANCE

Insurance Co. Name _____
Address _____
_____
Phone # _____ Ext. _____
Group # (Plan, Local or Policy #) _____
Policy Owner's Name _____
Relation to Patient _____
Policy Owner's Birthdate _____ ID # _____
Policy Owner's Employer _____
Employer's Address _____
_____
Orthodontic Coverage? ☐ Yes ☐ No

6 SECONDARY DENTAL INSURANCE

Insurance Co. Name _____
Address _____
_____
Phone # _____ Ext. _____
Group # (Plan, Local or Policy #) _____
Policy Owner's Name _____
Relation to Patient _____
Policy Owner's Birthdate _____ ID # _____
Policy Owner's Employer _____
Employer's Address _____
_____
Orthodontic Coverage? ☐ Yes ☐ No

7 VISIT INFORMATION

Reason for visit? _____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does the child brush his / her teeth daily? ☐ Yes ☐ No

Floss his / her teeth daily? ☐ Yes ☐ No

Child's Physician _____

Phone # _____ Date of last visit _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Has the child ever taken Fosamax,Actonel, Boniva or any other bisphosphonate? ☐ Yes ☐ No

Please list all medication that the child is currently taking:

_____

_____

Aside from items listed below, last all medications/things that the child is allergic to: _____

_____

Latex ☐Yes ☐No Metals ☐Yes ☐No Plastic ☐Yes ☐No

8 MEDICAL INFORMATION

Has child ever had any of the following medical problems?

Y	N		Y	N	
☐	☐	Abnormal Bleeding	☐	☐	Handicaps / Disabilities
☐	☐	ADD / ADHD	☐	☐	Hearing Impairment
☐	☐	Anemia	☐	☐	Heart Murmur
☐	☐	Any Hospital Stays	☐	☐	Hemophilia
☐	☐	Any Operations	☐	☐	Hepatitis
☐	☐	Artificial Bones / Joints /	☐	☐	Hives
☐	☐	Valves Asthma	☐	☐	HIV+ / AIDS
☐	☐	Cancer	☐	☐	Kidney / Liver Problems
☐	☐	Chicken Pox	☐	☐	Measles
☐	☐	Congenital Heart Defect	☐	☐	Mononucleasis
☐	☐	Convulsions	☐	☐	Rheumatic / Scarlet Fever
☐	☐	Diabetes	☐	☐	Sickle Cell Disease / Traits
☐	☐	Epilepsy	☐	☐	Skin Rash
☐	☐	Exposed to HIV, but Neg.	☐	☐	Tuberculisis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems that the child has had:

_____

_____

Does / did the child have any of the following habits?

Y	N		Y	N	
☐	☐	Lip Sucking / Biting	☐	☐	Nursing Bottle Habits
☐	☐	Nail Biting	☐	☐	Thumb / Finger Sucking

Was the child breast fed? ☐ Yes ☐ No

OUR OFFICE IS HIPPA COMPLIANT AND IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA

I affirm that the information I have given is correct to the best of my knowledge, it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in child's medical status. I authorize the dental staff to perform the necessary dental services my child my need.

Method of payment will be _____ Signature of parent or guardian _____ Date _____

I certify that my child is covered by _____ Insurance Co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent or guardian _____ Date _____

THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT AT TIMES OF SERVICES UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments _____

_____

_____

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____

2. Date _____ Comments _____ Signature _____