Please Complete Both Sides and Bring to Your Child's Appointment. Thank You.

Kids Smiles Pediatric Dentistry
49050 Schoenherr Rd; #400
Shelby Twp, MI 48315
586.247.5544

PATIENT INFORMATION

CHILD'S FULL NAME: _____ NICK NAME: _____

CHILD'S BIRTH DATE: _____ AGE: _____ SEX: (Circle) M F

CHILD LIVES WITH: (Circle) **Both Parents** **Mother** **Father** **Guardian** **Grandparents**

CHILD'S HOME ADDRESS:_____ CITY: _____ ZIP: _____

HOME PHONE: _____ EMAIL ADDRESS: _____

NAMES OF OTHER FAMILY MEMBERS WHO ARE PATIENTS IN THIS PRACTICE:

_____ _____ _____

ALTERNATE NUMBER - Emergency

(Friend, neighbor, relative, etc.)

Name: _____ Relationship to Child: _____ Phone: _____

REFERRAL SOURCE

We appreciate the referral of patients to our office and like to send a special "thank you". Whom may we thank for referring you to us?

Name: _____ Relationship: _____

PARENT INFORMATION

FATHER'S FULL NAME:_____

Father Employed By:_____

Social Security #: _____

Driver's License # _____

Employer Phone #:_____

Birth Date: _____

MOTHER'S FULL NAME: _____

Mother Employed By:_____

Social Security #:_____

Driver's License #: _____

Employer Phone #:_____

Birth Date: _____

DENTAL INSURANCE INFORMATION

Insured Party's Name:_____

Employer: _____

Group #: _____

Contract # _____

Relationship to Child:_____

Insurance Co.: _____

Insurance Phone #: _____

IF MORE THAN ONE INSURANCE COVERAGE, PLEASE COMPLETE:

Insured Party's Name: _____

Employer:_____

Group #:_____

Contract #: _____

Relationship to Child:_____

Insurance Co.: _____

Insurance Phone #: _____

Payment for services is required at each appointment.
The adult who brings the child to the office is financially responsible.

Form PI 209

It is your responsibility to inform us of any changes in your child's health. Thank you.

Family Physician or Pediatrician: _____

MEDICAL HISTORY

CONDITION	YES	NO	CONDITION	YES	NO	CONDITION	YES	NO
AIDS or HIV Positive			Counseling			Hyperactivity		
Acid Reflex/GERD			Cystic Fibrosis			Kidney Disorder		
Artificial Prosthesis			Developmentally Impaired			Muscular Dystrophy		
Asthma			Diabetes			Motor Skills Delayed		
Attention Deficit Disorder			Eating Disorder			Radiation Treatment		
Bleeding Disorder/Anemia			Epilepsy			Rheumatic Fever		
Blood Transfusion			Hearing Impaired			Shunt		
Brain/Nerve Damage			Heart Disorder/Surgery			Speech Delayed		
Cerebral Palsy			Heart Murmur			Surgery		
Chemotherapy			Hepatitis/Liver Disorder			Vision Impaired		
Tuberculosis			Autism					
Other _____								

Please explain any YES answers or other health problems: _____

Is your child: allergic to ☐ Penicillin ☐ Erythromycin ☐ Ceclor ☐ Sulfa ☐ Other _____
☐ Food ☐ Medicine ☐ Environmental

Taking any medicine now? (Circle) YES NO Explain: _____

At the appropriate grade level for his/her age? (Circle) YES NO Explain: _____

Is there anything in the patient's background that we should know to help us better relate to him/her? (Circle) YES NO If yes, explain below:

_____

DENTAL HISTORY

Any previous dental experience? (Circle) YES NO Where: _____

What was done: _____ When: _____

Child's reaction: _____ Parent's reaction: _____

Main dental concerns: _____

Has your child ever had injuries to the head or neck? (Circle) YES NO Explain: _____

Does your child have any oral habits? (Circle) Thumb Finger Pacifier Other _____

Who brushes your child's teeth? _____ When? _____

Names and ages of other children in the household: _____

DIETARY HISTORY

Does your child snack frequently? (Circle) YES NO On what? _____

Does your child drink juice frequently? (Circle) YES NO What kind? _____

Many fruit juices have natural acids which can cause cavities if taken frequently

Does/did your child take a bottle to bed? (Circle) YES NO Explain: _____

Is your home water supply fluoridated? (Circle) YES NO Does your child take a fluoride supplement? (Circle) YES NO

Because your child is a minor, signed permission is required from a parent or guardian for any dental treatment.

Signature: _____ Date: _____
(Parent/Guardian)

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