Kids Smiles Pediatric Dentistry

New Patient Form: Children Under 1 Year

We would like to welcome you and your child to our office! Our practice goal is to improve the lives of children by optimizing their oral health which will benefit their overall wellness. We will accomplish this state of the art treatment with a friendly approach focusing on the child's special needs.
Please fill out this form, print, sign, and bring with you to your appointment.

Patient Information

Name:_____ Nickname:_____

Date of Birth:_____ Male ☐ Female ☐ Social Security #_____

Home Address:_____

Parent/Guardian Information

Name:_____ Relationship to patient:_____

Home Address (if different): _____

Phone numbers: Home: _____ Work: _____ Mobile:_____

Email Address: _____

Dental Insurance Information

Insurance Company Name:_____ Group #:_____

Insurance Company Phone: _____ Insured Name: _____

Relationship to patient: _____

Insured SSN: _____ Insured Date of Birth:_____

Insured Employer:_____

Referred By: _____

Previous Consultations ☐ Yes ☐ No Doctor: _____

Medical History

☐ Full Term Birth or ☐ Premature Birth ___weeks. Any birth complications? ☐ No ☐ Yes:

_____

Any medical issues after birth? ☐ No ☐ Yes_____

Hospital/Birthing Center/Home birth:_____

Patient Name:_____

Birth Weight: _____ Current Weight:_____ Breast Feeding: ☐ Yes ☐ No

Bottle Feeding: ☐ No ☐ Yes: ☐ Breastmilk ☐ Formula: _____

Breastfeeding Problems:

☐ Latch Issues ☐ Milk Transfer Issues ☐ Excessive Air/Gas ☐ Lip Blister

☐ Staying on Breast ☐ Long BF Session ☐ Feeding Frequency ☐ Reflux

☐ Maternal Pain/Symptoms _____

Lactation Consultant:_____

Has your child had any of the following conditions?

☐ Anemia ☐ Cleft Lip/ Cleft Palate ☐ Hearing Impairment

☐ Asthma or Lung Problems ☐ Delayed Development ☐ Jaundice

☐ Kidney Disease ☐ Heart Condition ☐ Sickle Cell Anemia

☐ Bleeding Disorder ☐ Failure to Gain Weight

☐ Cerebral Palsy ☐ HIV

Any problems not listed above ☐ No ☐ Yes:_____

Please list all medications your child is currently taken: ☐ None

_____

Is Your Child ALLERGIC or has your child had an ADVERSE REACTION to any medication?

☐ No ☐ Yes: _____

Surgeries or Anesthesia History: ☐ None ☐ Yes:_____

Any history of life-threatening anesthesia complications in the family? ☐ No ☐ Yes:_____

_____

Primary Physician/Pediatrician:_____

Other Physicians/Specialists:_____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's medical status.

I have had full opportunity to read the Consent form and Notice of Privacy Practices (HIPAA).

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved. I have had full opportunity to read the Office Financial Policies.

Parent/Guardian Name_____ Date: _____

Signature:_____