Little Smiles
Pediatric Dentistry & Orthodontics
31646 Dunlap Blvd., Suite C, Yucaipa, CA 92399
Phone: (909) 794-4909 • Fax: (909) 794-4904

Tell Us About Your Child

Today's Date: _____ Child's Name: _____ Child's Birthdate: __/__/____ Child's Age: _____
Nickname: _____ ☐ Male ☐ Female School: _____ Grade: _____
Child's Home Address: _____
Who may we thank for referring you? _____
What is the primary reason for today's visit? _____
Has any member of your family been or is currently a patient in this office? ☐Yes ☐No If yes, name: _____

Dental History

Is your child currently in pain? ☐Yes ☐No Is this your child's first dental visit? ☐Yes ☐ No
Has your child experienced problems with previous dental work? ☐Yes ☐ No
If so, explain: _____
Previous Dentist: _____ Date of Last Visit: _____ Date of Last X-Ray: _____
Why did you leave your previous dentist? _____
What did you like most about any dentist you have seen? _____ Least? _____
Have there been any injuries to your child's teeth, jaws, falls, blows, chips, etc.? ☐Yes ☐No
Does your child take fluoride vitamins or drink fluoridated water? ☐Yes ☐No
Has your child been seen by an orthodontist? ☐Yes ☐No Who? _____
Would you or your child be interested in a complimentary orthodontic consultation? ☐Yes ☐No
Does your child brush his/her teeth daily? ☐Yes ☐No Does he/she require parental help? ☐Yes ☐No
Does your child floss his/her teeth daily? ☐Yes ☐No Does he/she require parental help? ☐Yes ☐No
Name of Parent's dentist: _____ City: _____ Phone: (___) _____

Does/did your child have any of the following habits? (please circle)

Y N Lip Sucking and Nail Biting	Y N Clenching/Grinding Teeth	Y N Tongue/Cheek Biting	Y N Mouth Breather
Y N Chewing on Objects	Y N Thumb/Finger Sucking	Y N Used Pacifier	Y N Speech Problems
Y N TMJ/TMD Pain	Y N Nursing Bottle Habits	Y N Tongue Thrust	Y N Breast Fed

Medical History

Child's Physician: _____ Phone: _____ Date of last visit: _____
Address: _____
Is your child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____
Does your child have social/personallity/temperament concerns that we should be aware of? _____
Is your Child pregnant or is there a possibility that she may be pregnant? ☐ Yes ☐ No
Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor Are Immunizations Current? ☐Yes ☐No
Please list all medications and dosage that your child is currently taking: _____
_____
Please list all drugs and/or things that cause your child allergic reactions: _____
Anything you would like to discuss with the Doctor in Private? ☐Yes ☐No
Has your child had/exprienced any of the following:(please circle)

Y N Abnormal Bleeding	Y N Congenital Birth Defect	Y N Heart Murmur	Y N Mononucleosis
Y N AIDS/HIV+	Y N Congenital Heart Defect	Y N Hemophilia	Y N Recurrent Headaches/Frequency
Y N Allergies	Y N Diabetes	Y N Hepatitis	Y N Rheumatic Fever
Y N Anemia	Y N Endocrine System Disorders	Y N High Blood Pressure	Y N Seizures
Y N Any Hospital Stays	Y N Epilepsy	Y N Hives	Y N Scarlet Fever
Y N Any Operations	Y N Frequent Infections	Y N Kidney Problems	Y N Sickle Cell Anemia
Y N Asthma	Y N Handicaps	Y N Liver/GI System Problems	Y N Sight Disorders
Y N Blood Transfusion/Date	Y N Latex Allergy	Y N Lupus	Y N Significant Injuries/What
Y N Breathing/Lung Problems	Y N Behavior/Learning/Disabilities	Y N Measles	Y N Skin Rash
Y N Cancer/Tumors	Y N Mentally/Physically Disabled	Y N Mitral Valve Prolapse	Y N Tonsilitis
Y N Chicken Pox	Y N Hearing Impaired		Y N Tuberculosis (TB)

Please discuss any serious medical problems your child experiences/ed: _____

Parents Information

Father's name ______________________________

Birthdate ______________________________

Social Security ______________________________

Home phone (____) ______________________ Primary Phone ☐

Work phone (____) ______________________ Primary Phone ☐

Cell phone (____) ______________________ Primary Phone ☐

Drivers License ______________________________

Address if different from Child's ______________________________

____

How would you like to be notified for future appointments?

Text ☐ Phone ☐ Email address ______________________

Married ☐ Divorced ☐ Full custody ☐ Shared custody ☐

Mother's name ______________________________

Birthdate ______________________________

Social Security ______________________________

Home phone (____) ______________________________

Work phone (____) ______________________________

Cell phone (____) ______________________________

Drivers License ______________________________

Address if different from Child's ______________________________

____

How would you like to be notified for future appointments?

Text ☐ Phone ☐ Email address ______________________

Married ☐ Divorced ☐ Full custody ☐ Shared custody ☐

Insurance Information

Primary Insurance

Insurance Co. Name ______________________________

Phone (____) ______________________________

Address ______________________________

____

Group# ______________________________

Subscriber Name ______________________________

Social Security ______________________________

Date of Birth ______________________________

Employer ______________________________

Secondary Insurance

Insurance Co. Name ______________________________

Phone (____) ______________________________

Address ______________________________

____

Group# ______________________________

Subscriber Name ______________________________

Social Security ______________________________

Date of Birth ______________________________

Employer ______________________________

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for the services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

There will be a $50.00 fee for "No Show" or less than 24 hours cancellation appointments.

____

Signature Date

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and/or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

____

Signature Date

Medical history review: __ /