



**Pediatric Smiles**<sup>SM</sup>  
*Keeping Kids Smiling!*

**Patient Information**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Age:** \_\_\_\_\_

M / F    **Patient Lives With:** \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_ **SSN:** \_\_\_\_\_

**Employer:** \_\_\_\_\_ **Work Phone:** \_\_\_\_\_

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**Person Responsible for Account:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Billing Address:** \_\_\_\_\_

**Home #:** \_\_\_\_\_ **Cell #:** \_\_\_\_\_

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**Dental Insurance**

**Insurance Company:** \_\_\_\_\_ **Group #:** \_\_\_\_\_

**Policyholder's Name:** \_\_\_\_\_ **Employer:** \_\_\_\_\_

**Policyholder's DOB:** \_\_\_\_\_ **Policyholder's SSN:** \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_

## Dental History

Is this your child's first visit to the dentist? Y / N If not, how long since the last visit to the dentist? \_\_\_\_\_

Were any x-rays taken at previous dental visit? Y / N Have there been injuries to the teeth, face or mouth? Y / N  
If yes, please explain: \_\_\_\_\_

Why did you bring the child to the dentist today? \_\_\_\_\_

Does the child have any of the following habits:

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

Has the child ever had a serious or difficult problem associated with previous dental work? Y / N  
If yes, please explain: \_\_\_\_\_

Is the child's water fluoridated? Y / N Does the child take fluoride supplements? Y / N

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD) Y / N

Does the child brush his/her teeth daily? Y / N Does the child floss his/her teeth daily? Y / N

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## Health History

Has the child ever had any of the following conditions?

Abnormal Bleeding	Y / N	Handicaps/Disabilities	Y / N
Allergies to any Drugs	Y / N	Hearing Impairment	Y / N
Any Hospital Stays	Y / N	Heart Murmur	Y / N
Any Operations	Y / N	Hemophilia	Y / N
Asthma	Y / N	Hepatitis	Y / N
Cancer	Y / N	HIV+/AIDS	Y / N
Congenital Heart Disease	Y / N	Kidney/Liver Conditions	Y / N
Convulsions/Epilepsy	Y / N	Rheumatic/Scarlet Fever	Y / N
Pregnancy	Y / N	Allergies to Latex	Y / N

Please discuss any serious medical conditions the child has had:

Please list all drugs the child is allergic to:

Please list all drugs the child is currently taking:

Who may we thank for referring you? \_\_\_\_\_

Child's Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

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

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

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### OFFICE USE

I have reviewed the medical/dental information above for the patient named herein.

\_\_\_\_\_  
Doctor

\_\_\_\_\_  
Date



## Notice of Privacy Practices Patient Acknowledgement

Patient Name : \_\_\_\_\_ Date of Birth : \_\_\_\_\_

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes :

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to :
  - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature : \_\_\_\_\_ Date : \_\_\_\_\_

