Dr. J. Bradford Smith, D.D.S.
Family and Cosmetic Dentistry

Child & Adolescence – New Patient Paperwork

Patient Information

Today's Date: _____

Patient Name: _____ Birthdate: _____ Age: _____

Home #: _____ Cell #: _____ Email (Appt. Confirmations): _____

Address: _____

HOW DID YOU HEAR ABOUT US? _____

Responsible Party Information

Person Responsible for Account – must be parent/legal guardian who created the account with the practice and who completes the paperwork:

First Name: _____ Last Name: _____ Age: _____ Birthdate: _____

SS#: _____ Occupation: _____ Employer: _____ Work #: _____

Insurance Information

Primary Dental Insurance

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Policy #: _____ Group #: _____ Plan #: _____

Subscriber's Name: _____ Relationship to Patient: _____ Subscriber's DOB: _____

Subscriber's Social Security #: _____ Subscriber's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____ Insurance Co. Phone #: _____

Policy #: _____ Group #: _____ Plan #: _____

Subscriber's Name: _____ Relationship to Patient: _____ Subscriber's DOB: _____

Subscriber's Social Security #: _____ Subscriber's Employer: _____

Dental History

Reason for today's visit: _____ Is the child currently in pain: □ Yes □ No

What was done at last visit? _____ Last Cleaning: _____ How often do you brush: _____

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

Has the child ever had any injuries to his/her teeth, mouth, head or jaws? □ Yes □ No If yes, explain_____

Has the child experienced problems with previous dental work? □ Yes □ No If yes, explain_____

Is the child's water fluoridated? □ Yes □ No Is the child taking fluoridated supplements? □ Yes □ No

Does the child brush his/her teeth daily? □ Yes □ No Does an adult assist with brushing? □ Yes □ No

Previous/Present Dentist: _____ Date of last visit: _____

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

Y N Lip Sucking/Biting	Y N Clenching/Grinding Teeth	Y N Tongue/Cheek Biting
Y N Nail Biting	Y N Used Pacifier – until age ____	Y N Speech Problems
Y N Chewing on Objects	Y N Nursing/Bottle Habits – until age ____	Y N Tongue Thrust
Y N Mouth Breather	Y N Thumb/Finger Sucking – until age ____	Y N Still in Sippy Cup

Medical History

Child's Physician's: _____ Phone#: _____ Date of last visit #: _____

Address: _____
Street City State Zip

Is the child currently under the care of a physician? □ Yes □ No - If yes, Explain: _____

Please describe the child's current physical health? □ Good □ Fair □ Poor **Are immunizations current? □ Yes □ No**

Please list all drugs that the child is currently taking: _____

Please list all drugs that cause the child allergic reactions: _____

Anything you would like to discuss with the doctor in private? ____ Y ____ N If yes, Explain: _____

Has the child had/experienced any of the following:

Y	N	Abnormal Bleeding	Y	N	Cerebral Palsy	Y	N	Lupus
Y	N	Acid Reflux	Y	N	Chemotherapy / Radiation Treatment	Y	N	Measles
Y	N	ADHD	Y	N	Developmental Delay	Y	N	Mononucleosis (MONO)
Y	N	Aids/HIV+	Y	N	Diabetes: Type _____	Y	N	Mouth Sores
Y	N	Anaphylactic Reaction	Y	N	Epilepsy / Seizures	Y	N	Rheumatic Fever
Y	N	Anemia	Y	N	Hearing Impairments	Y	N	Scarlet Fever
Y	N	Asthma	Y	N	Hemophilia: Type _____	Y	N	Sickle Cell Anemia
Y	N	Autism/Related Disorder	Y	N	Hepatitis: Type _____	Y	N	Tonsillitis
Y	**N**	**ANY HEART CONDITION****	Y	N	High Blood Pressure	Y	N	Tuberculosis (TB)
Y	N	Cancer	Y	N	Kidney Problems	Y	N	Premed Needed-Cleaning
Y	N	Cleft Palate / Lip	Y	N	Liver Problems			

CHECK ANY OF THE FOLLOWING THAT HAVE CAUSED ALLERGIES/ADVERSE REACTIONS:

☐ **PENICILLIN** ☐ **TETRACYCLINE** ☐ **ERYTHROMYCIN** ☐ **SULFA** ☐ **CODEINE** ☐ **VALIUM** ☐ **BARBITURATES** ☐ **LATEX** ☐ **RED DYE**

☐ **ASPIRIN** ☐ **LOCAL ANESTHETICS** ☐ **NSAID/ADVIL/MOTRIN** ☐ **OTHER, Please Explain: _____**

FEMALE PATIENTS:

ARE YOU PREGNANT NOW? ☐ YES ☐ NO **PRACTICING BIRTH CONTROL?** ☐ YES ☐ NO

Any medical history not listed above? Please explain: _____

**If any heart condition, please specify here. If any medical history not listed above? Please explain: _____

_____

Authorization

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 changes in my medical status. I authorize the dental staff to perform the necessary dental services I may need. It is also my responsibility to inform this office of any changes in my insurance coverage. I understand that payment is due at the time services are rendered.

_____ _____ _____

Responsible Party's Signature | Please Print Responsible Party's Name | Date