

WELCOME KIDS

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!



Star Smiles
Children's Dentistry

Today's Date: _____

Tell Us About Your Child

General Information

Child's Name: _____
Last First Mi

Child's Birthdate: ____ / ____ / ____ Child's Age: _____

Nickname: _____ Male Female

School: _____ Grade: _____

Hobbies: _____

Child's Home# (____) ____ - ____ SS# _____

Child's Home Address: _____

City State Zip

Child's Pediatrician: _____

Pediatrician's Phone#: (____) ____ - ____

Who is accompanying the child today?

Do you have legal custody of this child? Yes No

Who may we Thank for referring you?

Other siblings in our practice:

Previous/Present Dentist:

Last Visit Date: _____ Phone#: (____) ____ - ____

If there are language difficulties, who can we contact to help communicate with you:
Name: _____

Parent's Information

Parent's Marital Status Single Married Partnered Divorced Separated
 Father Step Father Guardian Mother Step Mother Guardian

Name: _____

Birthdate: ____ / ____ / ____

Address: (If different than Child's):

SS#: _____ DL#: _____

Work#: (____) ____ - ____ Ext: _____

Home#: (____) ____ - ____ Cell#: (____) ____ - ____

Email: _____

Employer: _____

Employer's Address: _____

City State Zip

Name: _____

Birthdate: ____ / ____ / ____

Address: (If different than Child's):

SS#: _____ DL#: _____

Work#: (____) ____ - ____ Ext: _____

Home#: (____) ____ - ____ Cell#: (____) ____ - ____

Email: _____

Employer: _____

Employer's Address: _____

City State Zip

If you have dental Insurance Coverage for the Child, Please fill out below:

Insurance Co. Name: _____ Insurance Co Phone#: (____) ____ - ____

Insurance Co. Address: _____

Group# (Plan, Local, or Policy#): _____

Thank you for your help. If there is any information you think might be of value to us in treating your child, please feel free to comment. I certify that I have read and understand the above questions. I will not hold Dr. Wilson, his associates and other healthcare professionals on his staff responsible for any errors or omissions I may have made in the completion of this form.

Signature of Parent or Legal Guardian

Relationship to Patient

Witness

Date

CHILD'S MEDICAL AND DENTAL HISTORY

MEDICAL HISTORY

THE EYES, EARS, NOSE AND THROAT

- Y N Allergies
- Y N Chronic Earaches
- Y N Deafness/Hearing Loss
- Y N Speech Problems
- Y N Chronic Sore Throat/Tonsillitis
- Y N Tonsils/Adenoids Removed
- Y N Blindness/Low Vision

Dr's Note: _____

THE CIRCULATORY SYSTEM

- Y N Heart murmur
- Y N Antibiotics for previous dental work
- Y N Circulation Problems
- Y N Congenital Heart Problems
- Y N Heart Surgery
- Y N Artificial Heart Valve
- Y N Rheumatic or Scarlet Fever
- Y N Excessive Bleeding/Hemophilia
- Y N Hepatitis
- Y N Sickle Cell Anemia
- Y N HIV/AIDS
- Y N Leukemia
- Y N History of Blood Transfusion Date _____

Dr's Note: _____

THE STOMACH, LIVER, KIDNEYS, BLADDER

- Y N Stomach Problems
- Y N Diabetes
- Y N Kidney Problems
- Y N Bladder Problems

Dr's Note: _____

INFECTIONS AND SERIOUS ILLNESSES

- Y N Immunizations are up-to-date
- Y N Chicken Pox
- Y N Chemotherapy Date _____
- Y N Hospitalization Date _____
- Y N Cancer or other malignancies Type _____

Dr's Note: _____

THE LUNGS

- Y N Asthma Date _____
- Y N Uses Inhaler Daily As Needed
- Y N Uses Steroids
- Y N Bronchitis
- Y N Pneumonia
- Y N Tuberculosis

Dr's Note: _____

THE NERVOUS SYSTEM, MUSCLES AND BONES

- Y N Epilepsy
- Y N Fainting
- Y N Cerebral Palsy
- Y N Nervous Problems
- Y N Mental Retardation
- Y N Down Syndrome
- Y N Autism
- Y N Attention Deficient Disorder

(continued up top)

- Y N Head trauma/Brain Injury
- Y N Spina Bifida
- Y N Muscular Dystrophy
- Y N Orthopedic Problems
- Y N Artificial Joints

Dr's Note: _____

ALLERGIES

- Y N Allergy to food, food additives
- Y N Allergy to household items, dust, pets
- Y N Allergy to plants, pollen, grass
- Y N Allergy to latex rubber
- Y N Allergy to Drugs Specify _____

Dr's Note: _____

GROWTH AND DEVELOPMENT

- Y N Prematurely or complicated pregnancy
- Y N Birth defects
- Y N Concerns with growth
- Y N Learning, behavioral, or communication problems
- Y N Psychological problems, testing or counseling
- Y N Alcohol, tobacco, or drug use

Dr's Note: _____

List any medications your child is presently taking:

Is there anything else we need to know about your child's medical history?

Dr's Note: _____

REVIEWED BY DOCTOR _____

DENTAL HISTORY

- Y N This is my child's first dental visit
- Y N My child is worried about today's visit
- Y N My child's previous visits were unsatisfactory
- Y N My child had an accident, hurting the head, mouth, or teeth
- Y N My child has had a toothache recently
- Y N My child has had regular dental exams and cleanings
- Y N Last exam, cleaning and fluoride Date _____
- Y N Dental xrays were taken earlier with Dr. _____
- Y N My child was breast or bottle fed for more than 1 year
- Y N My child sucks a thumb or fingers
- Y N My child uses a pacifier
- Y N My child is a mouth breather
- Y N My child grinds or clinches teeth
- Y N Injury to mouth and/or teeth
- Y N Bleeding gums
- Y N Do you help your child floss daily?
- How often are your child's teeth brushed per day?
- Once Twice After each meal None
- Y N Are there any other dental concerns to you as a parent?
- _____

Dr's Note: _____

REVIEWED BY DOCTOR _____

Complaints

Complaints about your privacy rights, or how this practice has handled your health information should be directed to our Privacy Officer by calling this office.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of ____/____/____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide this practice with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient's Name (print)

Patient's Signature

Date

Authorized Facility Signature

Date