

Dennis Miller, D.D.S., M.A.G.D.
Master in the Academy of General Dentistry
Courtney Miller-Reid, D.D.S., F.I.C.O.I., F.A.G.D.
Fellowship in the International Congress of Oral Implantologists
Fellow in the Academy of General Dentistry
Nicholas Reid, D.D.S., F.I.C.O.I., F.A.G.D.
Fellowship in the International Congress of Oral Implantologists
Fellow in the Academy of General Dentistry

Farmington Smiles
24001 Orchard Lake Rd Suite 160
Farmington, MI 48336
(248) 474-8060
Fax: (248)474-8460
Email: office@farmingtonsmiles.com

CHILD PATIENT INFORMATION

Today's date: _____

Child's name: _____ Birthdate: _____ Age: _____ Sex: _____
LAST FIRST MI

Child's Nickname: _____ School: _____ Grade: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____
 SS#: _____
 Home Phone #: _____ Mom's Cell Phone #: _____ Dad's Cell Phone #: _____
 Please circle best number to confirm appointments.

Mom's name: _____ Occupation: _____ Full Time Part Time
 Address (If different from Child's): _____ City: _____ State: _____ Zip: _____

Dad's name: _____ Occupation: _____ Full Time Part Time
 Address (If different from Child's): _____ City: _____ State: _____ Zip: _____

Parent's Relationship: Married Separated Divorced Never together Widowed
 Single Parent Guardian Foster Parent Other: _____

How many siblings? _____ Age(s): _____

Primary dental insurance: _____ Group #: _____
 Subscriber's name: _____ Date of birth: _____ SS#: _____
 Secondary dental insurance: _____ Group #: _____
 Subscriber's name: _____ Date of birth: _____ SS#: _____

EMERGENCY CONTACT Name: _____ Phone #: _____ Relation: _____

Child's medical doctor or clinic: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

Whom can we thank for referring you?: _____

DENTAL HEALTH HISTORY

Has there been any difficulty with dental treatment in the past? _____ If yes, please explain: _____

Has there been any injuries to your child's head/mouth/teeth? _____

Has your child ever sucked their thumb or finger(s)? YES (currently) YES (previously) NO
 If yes, what age? _____ Additional explanation: _____

Does your child have any speech problems? YES (currently) YES (previously) NO
 If yes, explain: _____

Has either parent had ortho treatment?..... YES NO

Any siblings that have had ortho treatment?.....YES NO

Do you notice your child grinding his/her teeth?..YES NO

Does your child brush his/her own teeth? YES NOHow many times a day? _____

Do you assist brushing his/her teeth? YES NOHow often? _____

Or, do you exclusively brush his/her teeth?..... YES NOHow often? _____

Is dental floss used?..... YES NOHow often? _____

Do you have well water? YES NOIs your child using Fluoride Supplements?YES NO

MEDICAL HEALTH HISTORY

Does your child have, or has he/she had, any of the following?

	YES	NO		YES	NO		YES	NO
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis or Respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>	Play musical Instrument?	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain.....	<input type="checkbox"/>	<input type="checkbox"/>	Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>	If yes, what instrument?	_____	
Shortness of breath.....	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers or acid reflux.....	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____ _____ _____		
High/low blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>	Kidney or bladder problems..	<input type="checkbox"/>	<input type="checkbox"/>			
Heart murmur.....	<input type="checkbox"/>	<input type="checkbox"/>	Bone or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>			
Artificial heart valve.....	<input type="checkbox"/>	<input type="checkbox"/>	Joint replacement.....	<input type="checkbox"/>	<input type="checkbox"/>			
Rheumatic fever.....	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells, seizures	<input type="checkbox"/>	<input type="checkbox"/>			
Blood Problems	<input type="checkbox"/>	<input type="checkbox"/>	ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>			
Easy bruising.....	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or neurological disease	<input type="checkbox"/>	<input type="checkbox"/>			
Frequent nosebleeds.....	<input type="checkbox"/>	<input type="checkbox"/>	Stroke(s)	<input type="checkbox"/>	<input type="checkbox"/>			
Abnormal bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>			
Anemia.....	<input type="checkbox"/>	<input type="checkbox"/>	History of head injury?	<input type="checkbox"/>	<input type="checkbox"/>			
Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>			
Ever have blood transfusion?	<input type="checkbox"/>	<input type="checkbox"/>	Check blood sugar daily.....	<input type="checkbox"/>	<input type="checkbox"/>			
Allergy Problems	<input type="checkbox"/>	<input type="checkbox"/>	Family history of diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>			
Sinus problems.....	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>			
Skin rashes.....	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis, jaundice, or liver trouble ..	<input type="checkbox"/>	<input type="checkbox"/>			
Asthma.....	<input type="checkbox"/>	<input type="checkbox"/>	Herpes or other STD	<input type="checkbox"/>	<input type="checkbox"/>			
Persistent cough or swollen glands	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ or AIDS	<input type="checkbox"/>	<input type="checkbox"/>			
Chronic Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>			

Has your child had any of the following operations? If yes, fill in the year of surgery.

Year

Tonsils removed..... _____

Adenoids removed..... _____

Tubes placed in ears..... _____

ALLERGIES

Is your child allergic, or has he/she reacted adversely, to any of the following?

	YES	NO
Local anesthetics ("Novocaine").....	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs.....	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen.....	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics.....	<input type="checkbox"/>	<input type="checkbox"/>
Latex.....	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

MEDICATIONS

YES NO DON'T KNOW

Premedication required by physician?.....

What prescription medications is your child currently taking?

Vitamin/Supplements/Natural Remedies:

∞ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

∞ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges, and any other expenses incurred in collecting your account.

∞ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

∞ I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I also understand it is my responsibility to inform this office of any changes to the information I have provided

UPDATE (OFFICE USE)

	Initial	Date
1. _____	/	_____
2. _____	/	_____
3. _____	/	_____
4. _____	/	_____
5. _____	/	_____
6. _____	/	_____

Patient/Guardian Signature : _____ Date: _____