

Patient ID # \_\_\_\_\_

Today's Date \_\_\_\_\_

**We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.**

### Your Child

Child's Name \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_  
 Nickname \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Birthdate \_\_\_\_\_  
 School \_\_\_\_\_ Grade \_\_\_\_\_  
 Child's Home Address \_\_\_\_\_  
 City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_ Phone \_\_\_\_\_

### Responsible Party

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Address \_\_\_\_\_ Email \_\_\_\_\_  
 City \_\_\_\_\_ State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 SS#/SIN \_\_\_\_\_ DL # \_\_\_\_\_  
 Who is Responsible for Making Appointments? \_\_\_\_\_

### Parent or Guardian Information

☐ Mother

☐ Stepmother

☐ Guardian

Name \_\_\_\_\_ Email \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 SS#/SIN \_\_\_\_\_ DL # \_\_\_\_\_  
 Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

### Parent or Guardian Information

☐ Father

☐ Stepfather

☐ Guardian

Name \_\_\_\_\_ Email \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
 SS#/SIN \_\_\_\_\_ DL # \_\_\_\_\_  
 Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

### Primary Insurance

Insured's Name \_\_\_\_\_ Relationship \_\_\_\_\_  
 Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_  
 Employer \_\_\_\_\_ Date Employed \_\_\_\_\_ Occupation \_\_\_\_\_  
 Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employee # \_\_\_\_\_

Please see reverse side

14450 Eagle Run Drive • Suite 290 • Omaha, Nebraska 68116  
 Phone: 402-964-9009 • Fax: 402-964-1077 • [www.SmileAcademyOmaha.com](http://www.SmileAcademyOmaha.com)

**Specialized Dentistry for Infants, Children, Teen and Special Needs Patients**

## Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # \_\_\_\_\_

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

Is your child's water fluoridated? ☐ Yes ☐ No

Does your child take fluoride supplements? ☐ Yes ☐ No

### Does your child:

Suck Thumb/Finger ☐ Yes ☐ No

Suck/Bite Lip ☐ Yes ☐ No

Bite/Chew Nails ☐ Yes ☐ No

Chew Hard Objects (pencils, etc.) ☐ Yes ☐ No

Grind Teeth ☐ Yes ☐ No

Clench Jaws ☐ Yes ☐ No

Date of Last Dental Visit \_\_\_\_\_

Previous Dentist \_\_\_\_\_

Address \_\_\_\_\_

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Has your child ever taken Fen-Phen/Redux? ☐ Yes ☐ No

Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Previous Hospitalizations/Surgeries/Serious Illnesses \_\_\_\_\_ When? \_\_\_\_\_

Is your child currently taking any medications? ☐ Yes ☐ No (if yes, please list) \_\_\_\_\_

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ Yes ☐ No

(if yes, please describe) \_\_\_\_\_

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? \_\_\_\_\_

Please explain any medical problems that your child has: \_\_\_\_\_

## Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check ☐ Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

### AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. 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 also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent/Guardian if minor) \_\_\_\_\_ Date \_\_\_\_\_

How Did You Hear About Us? *please circle one*

Website | Phonebook | Radio | Other: \_\_\_\_\_

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