Medical and Dental History Form

Child's name: _____ **Date of birth:** _____ **Gender:** □ Female □ Male

Please complete the following form so we may better serve your child:
What is the main reason you brought your child to us? (Chief complaint)_____

Has your child ever had any of the following:	Yes	No	Comments
Heart Murmur			
Congenital heart disease			
Asthma, Cystic Fibrosis, Respiratory Disease			
Diabetes, Thyroid, Glandular, or other Endocrine Disease			
Liver Disease/Hepatitis/Jaundice			
Kidney Disease			
Skin, Bone, Muscle, or Joint Disease			
Seizures/Convulsions/Loss of Consciousness			
Cerebral Palsy or Neurological Disease			
Sexually Transmitted Disease or HIV			
Anemia, Hemophilia, other Blood Disorders			
Sickle Cell Disease or Trait			
Cancer			
Speech disorder			
Hearing disorder			
Sight or eye disorder			
Frequent Headaches			
Mental, Emotional, or Developmental delays			
Autism, ADHD, Genetic Disorder/ Syndrome (please state)			
Frequent infections			
Has your child ever received blood/blood products?			
Has your child ever been hospitalized?			
Has your child ever been seriously ill?			
Has your child ever had a significant injury?			
Has your child ever had surgery?			
Does your child take any medicine?			
If so what medicine?			
Is your child allergic to any foods, environmental pollutants, animals, or medicines?			
If so, what foods, pollutants, animals, or medicines			

Is there any other disease or medical condition that we should know about in order to care for your child? □ No □ Yes, please list_____

What is the name and phone number of your child's Primary Physician? _____

_____

Has your child had any of the following:	Yes	No	Comments
Pain in the teeth			
Swelling of the mouth and face			
Injury to the face or teeth			
A bad dental experience			
Does your water have fluoride			
Does your child thumb suck, or other oral habit			
Does your child have any other dental condition			

Which of the following categories best describes your child's learning abilities? □ Delayed □ Normal □ Advanced

How do you think your child will cooperate for this appointment? □ Well-behaved □ Unsure □ Uncooperative

_____ _____ _____ _____
Date Parent/Guardian Reviewed By Date

Updated by: _____ _____
Updated by: _____ _____
Updated by: _____ _____
Updated by: _____ _____

Smith and Macdonald Pediatric Dentistry, LLC

Child's Name _____ Today's Date _____
Address _____ Home Phone _____
City _____ State _____ Zip _____ Sex _____M _____F
Child's Date of Birth _____Age_____ Grade _____ School _____
Who was your child's previous dentist?_____ When was their last cleaning and exam?_____

Responsible Party Information

Legal Guardian/Parent of a minor child is responsible for account.

Parent's marital status: Single ____ Married ____ Widowed ____ Separated ____ Divorced ____

Mother's Information:
Name _____ Home Phone _____
Address _____ Work Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Employer _____ Occupation _____
Date of Birth _____ SS# _____
Email_____(Used to confirm future appointments)

Father's Information:
Name _____ Home Phone _____
Address _____ Work Phone _____
City _____ State _____ Zip _____ Cell Phone _____
Employer _____ Occupation _____
Date of Birth _____ SS# _____

Insurance Information:

Primary Insured Information:
Name _____ Relationship to Patient _____
Employer _____ Group/Plan Number _____
Dental Ins. Co. _____ Phone Number _____
Insurance Co. Address _____
Insured S.S. # _____

Secondary Insured Information:
Name _____ Relationship to Patient _____
Employer _____ Group/Plan Number _____
Dental Ins. Co. _____ Phone Number _____
Insurance Co. Address _____
Insured S.S. # _____

Person to contact in case of emergency:
Name _____ Relationship _____ Phone _____
Whom may we thank for referring you? _____

Authorization:
I hereby authorize payment directly to Smith and Macdonald Pediatric Dentistry, LLC of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize Smith and Macdonald Pediatric Dentistry, LLC to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my child's dental/medical histories and other information about my child's dental treatment to third party payers and/or other health professionals. I also understand that credit bureau reports may be obtained if necessary. In the event that payment in full for charges incurred is not made, I agree to pay all cost of collection, including a 40% collection fee, attorney fees, court costs & interest at the rate of 1.5% per month (18% per year). In the event of a returned check, I agree to pay a returned check fee of $25.00. Payment is expected the date of service. If you have Insurance we will gladly process your claim, but require that you pay your estimated portion, co-payment or deductible at the time of dental visit.

_____ _____
Signature of Responsible Party Date