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

Child & Adolescence Paperwork Update

Patient Information

Today's Date: _____

Patient Name: _____ Birthdate: _____ Age: _____

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

Address: _____

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 #: _____

Medical History

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

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

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