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

Child & Adolescence – New Patient Paperwork

Patient Information

Today's Date: _______________

Patient Name: ____ Birthdate: ______________ Age: _______

Home #: ______________________ Cell #: ______________________ Email (Appt. Confirmations): ________________________________

Address: ____

HOW DID YOU HEAR ABOUT US? ____

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 #: _________________

Insurance Information

Primary Dental Insurance

Insurance Co. Name: ____ Insurance Co. Phone #: ______________________

Policy #: ______________________ Group #: ______________________ Plan #: ______________________

Subscriber's Name: __________________________________ Relationship to Patient: ______________ Subscriber's DOB: _____________

Subscriber's Social Security #: _____________________________ Subscriber's Employer: ____

Secondary Dental Insurance

Insurance Co. Name: ____ Insurance Co. Phone #: ______________________

Policy #: ______________________ Group #: ______________________ Plan #: ______________________

Subscriber's Name: __________________________________ Relationship to Patient: ______________ Subscriber's DOB: _____________

Subscriber's Social Security #: _____________________________ Subscriber's Employer: ____

Dental History

Reason for today's visit: ____ Is the child currently in pain: □ Yes □ No

What was done at last visit? ________________________________ Last Cleaning: ____________ How often do you brush: _____________

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? □ Yes □ No

Has the child ever had any injuries to his/her teeth, mouth, head or jaws? □ Yes □ No If yes, explain______________________________

Has the child experienced problems with previous dental work? □ Yes □ No If yes, explain______________________________

Is the child's water fluoridated? □ Yes □ No

Is the child taking fluoridated supplements? □ Yes □ No

Does the child brush his/her teeth daily? □ Yes □ No

Does an adult assist with brushing? □ Yes □ No

Previous/Present Dentist: ____ Date of last visit: ________________

Does/did your child have any of the following habits?

Y N Lip Sucking/Biting
Y N Nail Biting
Y N Chewing on Objects
Y N Mouth Breather

Y N Clenching/Grinding Teeth
Y N Used Pacifier – until age ____
Y N Nursing/Bottle Habits – until age ____
Y N Thumb/Finger Sucking – until age ____

Y N Tongue/Cheek Biting
Y N Speech Problems
Y N Tongue Thrust
Y N Still in Sippy Cup

Medical History

Child's Physician's: ____ Phone#: ______________________ Date of last visit #: ___________

Address: ____
Street City State Zip

Is the child currently under the care of a physician? □ Yes □ No - If yes, Explain: ____

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: _________________________________

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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